



# Module 3

Priority Populations  
Speak about Tobacco Control



Communities of Excellence  
in Tobacco Control

# MODULE 3

## **Priority Populations Speak about Tobacco Control**

California Department of Health Services, Tobacco Control Section

## **The Communities of Excellence consists of four modules:**

**Module 1:** Introduction to Communities of Excellence

**Module 2:** Conducting a Communities of Excellence Needs Assessment

**Module 3:** Priority Populations Speak about Tobacco Control

**Module 4:** Developing a Tobacco Control Intervention and Evaluation Plan

California Department of Health Services/Tobacco Control Section. 2006. *Communities of Excellence in Tobacco Control, Module 3: Priority Populations Speak about Tobacco Control*. Sacramento, CA: CDHS/TCS.

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# Section 1: An Overview of Tobacco-Related Disparities among California's Priority Populations

## Key Points

- Alarmingly high rates of smoking occur among several of California's demographic groups, including African Americans, American Indians and Alaska Natives, some Asian and Pacific Islander subgroups, Hispanic/Latino men, and the Lesbian, Gay, Bisexual, and Transgender (LGBT) community.
- Low Socioeconomic Status (Low SES) populations use tobacco at higher rates than higher socioeconomic status populations and suffer disproportionately from tobacco-related morbidity and mortality.
- Tobacco-related disparities are one small piece of a much larger picture of socioeconomic and health disparities facing California's diverse communities.
- Tobacco control efforts must take into account the interconnectedness between tobacco use and many of the other social, economic, and health issues facing priority populations.
- Health disparities encompass both health status and access to health care.
- Tobacco-related disparities involve issues related to prevalence, exposure to secondhand smoke, targeting by the tobacco industry, and priority populations' disparate capacities to address tobacco-related challenges.

Because the Communities of Excellence for Tobacco Control (CX) planning framework helps agencies design tobacco control plans that focus on significant, long-lasting social norm change, it is imperative for agencies working with priority populations to be familiar with and to understand their target communities' specific cultural, linguistic, and social characteristics. To that end, this Module contains a brief discussion of the issues surrounding disparities in tobacco control, followed by sections that seek to provide insight into the particular cultural, linguistic, and social characteristics that impact tobacco control work in several priority populations. These are African Americans; American Indians; Asian and Pacific Islanders; Hispanics/Latinos; Lesbian, Gay, Bisexual, and Transgender; and low socioeconomic

status groups. The California Department of Health Services acknowledges that there are other racial/ethnic populations and other groups of people with high tobacco use rates. In the future we hope to expand this module to incorporate other population groups. It is hoped that this background information will assist agencies in their needs assessments and subsequent development of their tobacco control plans.

## California's population: A majority of minorities

California is the most populous state in the nation, with 37 million people, and it continues to increase. By 2020, California's population is projected to reach nearly 44 million residents (Calif. Dept. of Finance 2004).

Furthermore, California is home to one of the world's most diverse populations. In fact, current population estimates indicate that no single race or ethnic group comprises a majority of the state's population. Thus, it comes as no surprise that the priority populations highlighted in this Module represent a significant number of California's residents (Calif. Dept. of Finance 2001, unless otherwise noted):

- The four priority populations defined by race or ethnicity add up to more than 17 million people:
  - African Americans: 2.2 million (6.4 percent of California's population)
  - American Indians and Alaska Natives: 387,000 (1.0 percent)
  - Asians and Pacific Islanders: 3.8 million (11.1 percent)
  - Hispanics/Latinos: 11 million (32.4 percent)
- Estimates of the population size of California's Lesbian, Gay, Bisexual, and Transgender (LGBT) community, which includes people of every race and ethnicity, range from 2 percent to 7 percent of the population (678,000 to 2.4 million) (GLMA 2001).
- The low socioeconomic status (Low SES) community, which includes LGBT people as well as people from all racial and ethnic groups, accounts for approximately 25 percent of the state's population, or about 9 million people.

## **Tobacco control disparities highlight the need to focus on priority populations**

Despite California's overall drop in smoking prevalence rates over the last fifteen years, certain demographic groups, in whole or in part, continue to have relatively high rates of tobacco use and exposure to secondhand smoke, and therefore suffer disproportionately from the health consequences and economic hardship caused by tobacco use.

In order to achieve further significant reductions in the overall smoking prevalence rate, smoking must be reduced in the population groups whose rates are the highest. The overall adult smoking prevalence rate in California is 14.2 percent (Combined Behavioral Risk Factor Survey and the California Adult Tobacco Survey 2005). The most recent data regarding the adult smoking prevalence rates for selected priority populations are as follows:

- African Americans: 19.0 percent (California Tobacco Survey 2002)
- American Indians: 30.1 percent (California Health Interview Survey 2001)
- Asian/Pacific Islanders: 12.1 percent (California Tobacco Survey 2002)
- Hispanics/Latinos: 13.4 percent (California Tobacco Survey 2002)
- LGBT: 30.4 percent (California Lesbian Gay Bisexual and Transgender Tobacco Use Study 2004)
- Low SES: 21.0 percent (California Tobacco Survey 2002)

It is important to note that aggregated data do not always tell the whole story. For example, even though the aggregated data for the Asian and Pacific Islander community shows a relatively low prevalence rate, very high prevalence rates exist for Laotian men, Cambodian men, and Korean men (Lew 2004; California Tobacco Survey 2002; CDHS/TCS California Korean American Tobacco Use Study 2004).

The tobacco control community in California and across the nation has known about these disparities for a long time, but creating significant and long-lasting social norm change around the issue of tobacco use has been challenging. The reasons for tobacco-related disparities are numerous, complex, and diverse: lack of access to culturally competent medical care, limited community resources, competing priorities, limited tobacco control infrastructure, cultural traditions, and predatory targeting by the tobacco industry all contribute to greater tobacco use in these communities.



## **Tobacco-related disparities reflect a larger picture of socioeconomic and health inequality**

Despite progress in California over the last several decades in social, political, and economic equity, disparities among demographic groups persist. Tobacco-related disparities reflect a larger picture of socioeconomic and health inequality that affects the lives of millions of Californians.

### **Placing tobacco control in the context of broader socioeconomic issues**

Although tobacco use is most often characterized as a singular health challenge, issues related to tobacco use and its consequences intersect with, and are influenced by, many other social and economic factors facing a community. Tobacco-related disparities must be understood and addressed in the context of broader issues of inequality; tobacco control work must be sensitive to, and appropriate for, the social context in which it occurs.

The context of tobacco control work for millions of Californians is one in which race, ethnicity, sexual orientation, and socioeconomic status continue to be strong predictors of health and well-being. Disparities in income, education, employment, housing, and health care, often resulting from bias and discrimination, both historical and continuing, form the backdrop of tobacco control efforts in these priority populations. This social context has several implications for tobacco control efforts, including mistrust of “outsiders” imposing priorities, agendas, and methods on communities that have suffered great injustices in the past, and a sense that tobacco control work is competing for limited resources with what are perceived to be more immediate and compelling issues.

Therefore, in order to be relevant, tobacco control efforts need to address the interconnectedness

between tobacco use and many of the other issues facing priority populations in culturally and linguistically appropriate ways.

A community’s health cannot be separated from its socioeconomic context. Income level, educational attainment, discrimination based on race, ethnicity, and sexual orientation, language barriers, immigration status, and cultural beliefs and customs all play a role in the health of individuals and communities. Of all these factors, low socioeconomic status may be the strongest predictor of health. Low SES individuals have poorer health, exhibit fewer healthy behaviors, and are less likely to pursue preventive health care than people of higher socioeconomic status (USDHHS Healthy People 2010).

Tobacco-related health issues fit within this pattern. Many studies have shown that Low SES Californians, many of whom are racial and ethnic minorities, use tobacco at higher rates than higher socioeconomic status populations and suffer disproportionately from tobacco-related morbidity and mortality. Because socioeconomic disparities are often at the root of tobacco-related disparities, it is important to become familiar with the socioeconomic challenges that priority populations are working to overcome.

What follows is a brief overview of some of the issues related to socioeconomic status, health, and tobacco use that form the social context for tobacco control work in priority populations. It is critical to remember, however, that each of these communities has a unique history and experience in the United States (U.S.), in California, and in the local communities where they live, work, and go to school. Therefore, the issues described below do not apply equally, either in quantitative or qualitative terms, to all the priority populations or their various subgroups.

### **Poverty and public assistance**

The demographics of poverty exhibit wide ethnic and racial disparities. Poverty rates are highest for

American Indians and Alaska Natives, African Americans, and Hispanics/Latinos and lowest for non-Hispanic Whites and Asians and Pacific Islanders. It is important to note, however, that some subgroups within the Asian and Pacific Islander community, such as

Southeast Asians, have low labor force participation rates, high levels of unemployment, and one of the highest rates of poverty of all racial and ethnic groups in California (Reyes 2001).

Racial and ethnic minorities' disproportionate presence among the ranks of the poor leads to an equally disproportionate number of encounters with the public assistance system. Health educators and program planners working in tobacco control sometimes see opportunities for outreach and intervention when low income individuals access social services. To be successful, however, such outreach efforts and interventions must take into account the context in which they occur. In one study, researchers with the U.S. Commission on Civil Rights observed the experiences of ethnic and racial minorities as they applied for and received public assistance. The study found that people of color frequently encountered insults and disrespect as they attempted to navigate the welfare system, and individuals with limited English proficiency encountered language barriers. Immigrants were often turned away because of misconceptions about their eligibility status.

The U.S. Commission on Civil Rights found clear disparities in access to and receipt of services across racial and ethnic lines. Caseworkers, who have great discretion in connecting recipients with available services, often discriminated, whether intentionally or not, in the services they offered. White recipients, for example, were more likely to be encouraged to pursue an education, were less

**Rates of Poverty by Race in California (2000 U.S. Census)**

<i>Demographic Group</i>	<i>percent</i>
African Americans	24.5
American Indians/Alaska Natives	25.7
Asians/Pacific Islanders	12.8
Hispanics/Latinos	22.6
Non-Hispanic Whites	8.1
Total Population	14.2

likely to be sanctioned, and were more likely to receive child care subsidies than other groups (U.S. Commission on Civil Rights 2002).

## **Housing and the living environment**

The nature of the buildings and neighborhoods in

which people live intersects with all the other factors influencing their physical, economic, and social well-being. Dilapidated housing, for example, is associated with exposures to lead, asthma triggers (such as mold, moisture, dust mites, and rodents), and other health consequences. The lack of sidewalks and recreation areas in low income neighborhoods discourages physical activity and contributes to obesity. In some neighborhoods, the threat of crime keeps many people inside, leading to mental stress and social isolation (Prevention Institute and APHA 2003). Low income neighborhoods often lack amenities such as supermarkets, and low income areas contain more places that sell alcohol, leading to a disproportionate incidence of injuries and violence. In addition, higher convenience store concentrations found in low income neighborhoods are significantly associated with higher levels of smoking (Hood 2005).

## **Education**

At the elementary school level, reading and math proficiency tests show substantial differences in scores across racial and ethnic groups. In California, more than two-thirds of Hispanic/Latino and African American fourth graders score below basic proficiency in reading and math compared to 35 to 45 percent of non-Hispanic Whites and Asians and Pacific Islanders. Using average test scores as a measure of school quality, it is apparent that, on average, Whites and Asians and Pacific Islanders attend better schools. At both the primary and secondary levels, schools serving

large concentrations of low-income students often have many inexperienced teachers, the sites are in poor states of maintenance, and both teachers and students lack proper instructional materials. High turnover of professional staff is common (Cheng 2001).

Generally speaking, Hispanics/Latinos fare worse than any other major racial or ethnic group in California in the area of education, and the low educational attainment of Hispanic/Latino adults is not simply a result of recent immigration. U.S.-born Hispanics/Latinos, particularly those of Mexican descent, have consistently lower high school and college completion rates than do African Americans, Asians and Pacific Islanders, or non-Hispanic Whites. Close to half of Mexicans in California and more than one-third of other Hispanics/Latinos have limited English-speaking ability. Limited English ability is also a concern for Asian and Pacific Islander immigrants, despite their relatively high educational attainment. Nearly 40 percent of Southeast Asians and between one-fourth and one-third of Chinese, Japanese, and Koreans reported limited English-speaking ability (Cheng 2001).

High school completion rates for California's African Americans are similar to those of Whites. On the other hand, college completion rates remain much lower for African Americans than for Whites (Cheng 2001).

Educational attainment among American Indian and Alaska Native adults is considerably lower than that of non-Hispanic Whites; American Indian and Alaska Native students are at least twice as likely to drop out of high school as their non-Hispanic White counterparts (U.S. Commission on Civil Rights 2004).

Educational attainment relates to health issues, including tobacco control. In fact, educational attainment has a direct correlation with health status and longevity—more years of education usually translate into more years of life. Higher levels of education may increase the likelihood of obtaining or understanding health-related information needed to develop health-promoting behaviors and beliefs

in prevention. Among people aged 25 to 64 years in the U.S., the overall death rate for those with less than 12 years of education is more than twice that of people with 13 or more years of education. Furthermore, the amount of education achieved by a woman is a key determinant of the welfare and survival of her children. The infant mortality rate is almost double for infants of mothers with less than 12 years of education compared with those with an educational level of 13 or more years (USDHHS Healthy People 2010).

## **Employment**

Low educational attainment translates into poor performance in the labor market. Nonwhites, especially Hispanics/Latinos, tend to have lower earnings than non-Hispanic Whites. Furthermore, Hispanics/Latinos and African Americans have particularly high unemployment rates, and their rates of unemployment are more severely affected by economic fluctuations. Low levels of education and recent immigration contribute to low earnings. However, even when U.S.-born workers from different racial and ethnic groups with similar education levels are compared, it is apparent that the median earnings of White men are higher than the median for Hispanic/Latino, Asian and Pacific Islander, or African American men (Reyes 2001). The unemployment rate for American Indians and Alaska Natives is two to three times higher than for non-Hispanic Whites (Ong 2004).

In terms of demographics, lower wage workers have less education, are younger, are predominately women and Hispanic/Latino, and live in lower-income households. In California, non-Hispanic White workers comprise over half of all workers but make up only a third of the lowest-wage workers (Reich and Hall 2001).

The most significant change in the state's labor force is the growth of the immigrant work force. California is home to 30 percent of the nation's legal immigrants and 40 percent of the nation's undocumented immigrants. The immigrant labor

force is comprised primarily of Hispanics/Latinos and Asians and Pacific Islanders; a third of all foreign born workers do not have a high school education. Because of low educational attainment and a lack of other marketable skills, immigrants are concentrated in low status occupations and low-wage jobs. This is particularly true for Hispanic/Latino immigrants, who have the lowest median earnings among the major immigrant and racial groups (Lincoln and Ong 2001).

## **Income and wealth**

As with other socioeconomic indicators, income levels vary by race and ethnicity. In terms of median household income, Whites, Asians, and Pacific Islanders have the highest medians, whereas American Indians and Alaska Natives, Hispanics/Latinos, and African Americans have lower median household incomes (Lopez 2002).

In terms of income trends, there is truth to the adage that the rich get richer and the poor get poorer: over the past decade, income inequality in California has increased. By the late 1990s, the richest 20 percent of families had average incomes 11 times larger as the poorest 20 percent of families (Economic Policy Institute 2002).

LGBT people are found throughout the spectrum of income distribution; some are poor, a few are rich, and most are somewhere in the middle, along with most heterosexual people. One study comparing the economic status of lesbian, gay, and bisexual (LGB) people with that of heterosexual people in the U.S. revealed the following findings (Badgett 1998):

- LGB people did not earn more than heterosexual people.
- LGB people did not live in more affluent households than heterosexual people.
- Men with male partners earned 26 percent less than married men with the same education, location, race, age, number of children, and disability status did.
- The findings for gay men strongly suggested the influence of workplace discrimination.

- Women with female partners showed no difference in earnings compared to heterosexual women once other factors were taken into account.

## **Crime and criminal justice**

There are striking disparities in arrest, incarceration, and victimization rates across California's major racial and ethnic groups, with African Americans having the highest rates of arrest and incarceration, especially for narcotics offenses, and the highest incarceration rates under California's "three strikes" law. At approximately seven percent of the population, African Americans account for 23 percent of the felony arrestees. In fact, in the 1990s, the chance that an African American male born in the U.S. would be imprisoned for a felony sometime in his lifetime approached 30 percent, while the chance for a non-Hispanic White male was 4 percent. African Americans are also more likely than others to be victims of violence and homicide (Reyes 2001).

Criminal justice is also of concern to the Hispanic/Latino community. In recent decades, the proportion of Hispanic/Latino youth and adults behind bars has risen at a faster rate than has the Hispanic/Latino proportion of the general population (Reyes 2001).

## **Political participation**

Because public policy is more responsive to the voting population than to the general population, disparities in political participation have important policy implications. Differences in political participation are due to differences in citizenship, voter registration, and election turnout rates among the state's major ethnic groups. In 2000, non-Hispanic Whites made up 70 percent of the voting population in California. The high citizenship rate among Whites accounts for a significant portion of their overrepresentation compared to Hispanics/Latinos and Asians and Pacific Islanders. Even among citizens, however, turnout differences are considerable. Between 1990 and 2000, for example,

White turnout was about 10 percentage points higher than that of African Americans and 18 points higher than that of Hispanics/Latinos and Asians and Pacific Islanders.

Factors that affect turnout rates, such as age, education, income, and residential stability, account for the relatively low rates of political participation by Hispanics/Latinos and African Americans. The lower participation of Hispanics/Latinos, in particular, can be traced to lower citizenship rates, relative youth, and lower socioeconomic status.

On the other hand, these factors do not fully explain the low political participation of Asian American citizens, who vote much less frequently than would be predicted on the basis of their socioeconomic status. Asian immigrants living in California have a relatively low citizenship rate (59 percent), and among foreign-born Asian citizens, turnout is barely 50 percent. This relative reluctance to participate in the political process may be rooted in cultural norms and beliefs about the value of voting. Those born in the Philippines and Vietnam have the highest rates of citizenship and the highest voting rates (Public Policy Institute of California 2002).

## Health disparities reflect broader issues

In the United States, racial and ethnic minorities often have less access to health care, receive lower-quality health care, and have higher rates of illness, injury, and premature death than their White counterparts. Inequalities in income and education underlie many, but not all, of these health disparities (IOM, 2002).

What is true for the nation as a whole is also true in California: people of color in California consistently face higher rates of morbidity and mortality than non-Hispanic Whites. These higher rates are experienced across a very broad spectrum of illnesses and injuries. Racial and ethnic health disparities are generally not the result of people experiencing a different set of illnesses than

those affecting the general population. Rather, the diseases and injuries that affect the population as a whole affect people of color more frequently and more severely (Prevention Institute and APHA 2003). And, as mentioned previously, Low SES individuals, regardless of race or ethnicity, have poorer health, exhibit fewer healthy behaviors, and are less likely to pursue preventive health care.

The LGBT community faces its own set of health challenges, due largely to the fact that gay and lesbian partners of insured individuals are often denied health care coverage, as well as discrimination and prejudice by health care providers and a shortage of culturally competent health care services (GLMA 2001).

It can be helpful to look at the broad concept of health as two separate but related areas: (1) physical and mental health status and (2) access to health care, including health insurance coverage.

### Disparities in physical health and mental health status

Generally speaking, in California, as in the U.S. as a whole, African Americans, American Indians and Alaska Natives, and Hispanics/Latinos fare worse in terms of morbidity and mortality than non-Hispanic Whites and Asians and Pacific Islanders. However, generalizations about the health of Hispanics/Latinos and Asians and Pacific Islanders have a tendency to obscure important differences in the health of these communities' subgroups. For example, although people of Japanese, Chinese, and Korean ancestry tend to enjoy better health than Whites, people of Southeast Asian and Filipino ancestry have comparatively poor health outcomes. And, although Mexicans have poorer access to health services such as prenatal care, they have better birth outcomes than other Hispanic/ Latino groups (Prevention Institute and APHA 2003).

Below is a brief summary of the major health issues facing selected priority populations.

**African Americans:** The health disparities between African Americans and other racial groups are striking and are apparent in life expectancy, infant mortality, and other measures of health status. For example, in 1999 the average American could expect to live 76.9 years, whereas the average African American in the U.S. could expect to live only 71.4 years. Key health concerns for the African American community include heart disease and stroke, cancer, diabetes, hypertension, and HIV/AIDS (CDHS/Center for Health Statistics 2003; USDHHS Healthy People 2010; Prevention Institute and APHA 2003).

**American Indians and Alaska Natives:** American Indians and Alaska Natives suffer disproportionately from many health conditions, including diabetes, alcoholism, tuberculosis, suicide, unintentional injuries, pneumonia, and influenza. This community has an infant death rate almost double that for Whites. As a result of increased mortality rates, the life expectancy for Native Americans in the U.S. is 71 years of age, nearly five years less than the rest of the U.S. population (CDHS/Center for Health Statistics 2003; Healthy People 2010; Prevention Institute and APHA 2003).

**Asians and Pacific Islanders:** Asians and Pacific Islanders, on average, have indicators of being one of the healthiest population groups in the U.S. However, there is great diversity within this population group, and health disparities do arise for some specific segments of the population. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate of non-Hispanic White women. In addition, new cases of hepatitis and tuberculosis are higher in Asians and Pacific Islanders living in the U.S. than in non-Hispanic Whites (CDHS/Center for Health Statistics 2003; USDHHS Healthy People 2010; Prevention Institute and APHA 2003).

**Hispanics/Latinos:** Hispanics/Latinos living in the U.S. are almost twice as likely to die from diabetes as are non-Hispanic Whites, and Hispanics/

Latinos have higher rates of high blood pressure and obesity than non-Hispanic Whites. There are differences within the Hispanic/Latino community, as well. For example, whereas the rate of low birthweight infants is lower for the total Hispanic/Latino population compared with that of Whites, Puerto Ricans have a low birthweight rate that is 50 percent higher than the rate for non-Hispanic Whites (CDHS/Center for Health Statistics 2003; USDHHS Healthy People 2010; Prevention Institute and APHA 2003).

**LGBT:** The LGBT population comprises a diverse community with disparate health concerns. Major health issues for gay men are HIV/AIDS and other sexually transmitted diseases, substance abuse, depression, and suicide. Key health concerns for lesbians are a high prevalence of smoking, cancer, obesity, alcohol abuse, and stress. Social conditions—issues surrounding personal, family, and social acceptance of sexual orientation—impact the health of LGBT people in a variety of ways. The areas affected range from the direct impact of stigmatization and prejudice (such as exposure to violence, stress, and poor access to care) to the failure to adequately address special needs of LGBT populations (e.g., gay-specific sexually transmitted disease, fertility challenges, and gender reassignment surgery) (GLMA 2001).

**Low SES:** Low SES individuals have poorer health, exhibit fewer healthy behaviors, and are less likely to pursue preventive health care than those of higher socioeconomic status. The socioeconomic differences apparent in risk factors (smoking, obesity, elevated blood lead, and sedentary lifestyle), as well as differences in access to and utilization of health care, influence the relatively high rates of poor health outcomes such as low birthweight, heart disease mortality, diabetes mortality, and activity limitations. Some researchers speculate that simply being on the lower end of the socioeconomic spectrum exacts an emotional and psychological toll that translates into poorer physical

and mental health (Pamuk et al. 1998). Studies have found that unemployment, poverty, and housing unaffordability are correlated with a risk of mental illness (Hudson 2005).

Below is a closer look at some of the specific health conditions facing California's priority populations. Keep in mind that opportunities exist for tobacco control programs to forge links and find common ground with health care professionals and community-based organizations that specialize in illnesses and conditions of particular concern to priority populations.

### Physical health

**Asthma:** Substandard housing, high concentrations of local ambient air pollution, and other negative aspects of neighborhood built environments contribute to the disproportionate prevalence and incidence of asthma among low income urban children (Hood 2005). Studies of lower income asthmatic children also show that exposure to violence exacerbates asthma symptoms. American Indian and Alaska Native children have the highest asthma prevalence of all racial/ethnic groups (25 percent) in California, compared to 22 percent for Native Hawaiian and other Pacific Islanders, 21 percent for African Americans, 14 percent for non-Hispanic Whites, 12 percent for Asians, and 10 percent for Hispanics/Latinos. In 2000, a higher percentage of Hispanics/Latinos, African Americans, and American Indians and Alaska Natives required emergency room visits for their asthma as compared to Asians and Pacific Islanders or non-Hispanic Whites (Prevention Institute and APHA 2003).

**Cancer:** Cancer is an area where specific population groups experience disparities in incidence, prevalence, mortality, survival, risks, and treatment. According to the U.S. Centers for Disease Control and Prevention (CDC), higher rates of lung, cervical, and stomach cancer are associated with Low SES, along with lower survival rates for most forms of cancer. Among ethnic and racial groups, African Americans are more likely to die of cancer

than people of any other racial or ethnic group. For example, cancer incidence rates for prostate, lung and brochus, and colorectal cancer are higher for African American males than for males of other racial and ethnic groups (CDC 2005).

**Cardiovascular Disease:** Racial and ethnic disparities are most evident in cardiovascular care. Heart disease is the leading killer across most racial and ethnic minority communities in the U.S. African Americans are 29 percent more likely to die from heart disease than non-Hispanic Whites, and African Americans suffer disproportionately from hypertension compared to Whites. Mexican Americans, who make up the largest share of the U.S. Hispanic population, suffer in greater percentages than Whites from overweight and obesity, two leading risk factors for heart disease. Premature death from cardiovascular disease is higher for Hispanics than non-Hispanics. In 2001, the number of premature deaths (occurring at less than 65 years of age) from heart disease was greatest among American Indians and Alaska Natives and lowest among Whites (USDHHS Office of Minority Health(a), citing CDC statistics).

**Diabetes:** Racial and ethnic minorities suffer at disproportionately high rates from diabetes and its serious complications. According to the CDC's Office of Minority Health, African Americans are 2.4 times as likely to have diabetes as non-Hispanic Whites of the same age, Hispanic adults are 1.5 times as likely to have diabetes as non-Hispanic Whites, and American Indians and Alaska Natives are 2.3 times as likely to have diabetes as their non-Hispanic White counterparts. In addition, African Americans and American Indians and Alaska Natives have higher rates of diabetes-related complications such as kidney disease and amputations (USDHHS Office of Minority Health(b), citing CDC statistics).

**HIV/AIDS:** The rate of HIV infection among African Americans is almost four times higher than that of non-Hispanic Whites or Hispanics/Latinos, while Hispanics/Latinos have the highest rates of new

infection among California residents under the age of 30. As of 2002, 40.5 percent of the adult/adolescent cases and 72 percent of the pediatric cases of HIV/AIDS occurred in people of color. African Americans in California are more than three times more likely to die from HIV/AIDS than their White counterparts (Prevention Institute and APHA 2003).

**Infant mortality:** According to the Institutes of Medicine (IOM), African American and American Indian and Alaska Native infant mortality rates are approximately 2.5 and 1.5 times higher, respectively, than rates for non-Hispanic Whites. Most of the disparity in infant mortality among African Americans is attributed to three factors: large numbers of infants born at low birthweight and/or pre-term, complications at pregnancy, and Sudden Infant Death Syndrome (Prevention Institute and APHA 2003).

**Low birthweight babies:** African Americans have the highest rate of low birthweight delivery in California, as they do nationally. Low birthweight babies are substantially more likely to die or be ill in their first year of life. Several studies point to the conclusion that the high rate of low birthweight delivery in the African American community can be attributed largely to Low SES (Prevention Institute and APHA 2003).

## **Mental health**

**African Americans:** According to the U.S. Surgeon General, African Americans have rates of mental illness similar to their White counterparts, but differences arise in the prevalence of specific illnesses and in the quality of treatment they receive for mental illness. For example, African Americans may be less likely to suffer from major depression and more likely to suffer from phobias than non-Hispanic Whites. Once they are in psychiatric care, African-Americans are more likely to be diagnosed as psychotic, but are less likely to be given anti-psychotic medications. They are more likely to be hospitalized involuntarily, to be regarded as

potentially violent, and to be placed in restraints (IOM 2002). African Americans are overrepresented in populations at particular risk for mental illness, such as the homeless, people who are incarcerated, children in foster care, and people exposed to violence. According to the National Alliance for the Mentally Ill (NAMI), African Americans tend to rely on family and on religious and social communities for emotional support, rather than turning to health care professionals, and mental illness is frequently stigmatized and misunderstood in the African American community (NAMI fact sheet: African American Community Facts about Mental Health).

**American Indians and Alaska Natives:** In the American Indian and Alaska Native community, the most significant mental health concerns are the high prevalence of depression, substance abuse, anxiety, violence, and suicide. Depression is the most serious emerging mental health disorder in the Native American population. One of the more troubling indicators is reflected in suicide rates. From 1985 to 1996, American Indian children committed suicide at two and one-half times the rate of White children. The suicide rate for American Indians continues to escalate and is twice the rate of the general population. Native Americans use and abuse alcohol and other drugs at younger ages, and at higher rates, than all other ethnic groups. Consequently, their age-adjusted alcohol-related mortality rate is 5.3 times greater than that of the general population (U.S. Commission on Civil Rights 2004).

**Asians and Pacific Islanders:** According to the Asian and Pacific Islander American Health Forum (<http://apiahf.org/>), Asians and Pacific Islanders have the lowest utilization rates for mental health care among all populations, regardless of gender, age, and geographical location. That does not mean that mental health issues are nonexistent in the Asian and Pacific Islander community, however. The National Asian American Pacific Islander Mental Health Association (<http://www.naapimha.org/>) reports the following:



- Asian and Pacific Islander females have among the highest suicide rates of any ethnic group between the ages of 15-24 and over the age of 65.
- Native Hawaiian youth have significantly higher rates of suicide attempts than other adolescents in Hawaii.
- 40 percent of Southeast Asian refugees suffer from depression, 35 percent from anxiety, and 14 percent from Post Traumatic Stress Disorder.
- 30 percent of Asian American girls in grade 5 through 12 reported depressive symptoms as compared to non-Hispanic White (22 percent), African American (17 percent) and Hispanic/Latina (27 percent) girls.
- Asian American elders show a greater prevalence of dementia than the general population.
- The suicide rate among Chinese American elderly women has been found to be 10 times higher than for White elderly women.

**Hispanics/Latinos:** According to NAMI, the rates of mental illness in the Hispanic/Latino community are fairly similar to those for non-Hispanic Whites. Hispanics/Latinos are identified as a high-risk group for depression, anxiety, and substance abuse. Other mental issues in the Hispanic/Latino community include the following:

- Depressive symptoms, including attempted suicide and suicidal thoughts, are exhibited at a high rate among Hispanic/Latina girls.
- U.S. born and long-term resident Hispanics/Latinos have higher rates of mental illness than more recent Hispanic/Latino immigrants.
- Due to a lack of cultural knowledge, Hispanic/Latino youth with mental illness are often misdiagnosed as having anger problems or conduct disorders.

(NAMI fact sheet: Latino Community Mental Health Facts)

**LGBT:** Evidence suggests that the LGBT community may disproportionately utilize mental health services, yet LGBT people have serious concerns about the quality of the services they receive,

given the well-documented history of classifying homosexuality and being transgendered as mental disorders in and of themselves. LGBT populations are likely at increased risk for mental distress, mental disorders, substance abuse, and suicide because of exposure to stressors related to societal anti-gay attitudes. Known social stressors include prejudice, stigmatization, and antigay violence. Transgendered persons suffer from feelings of shame, low self-esteem, isolation, loneliness, anxiety, and depression. LGBT youth are especially vulnerable as they grow up in a society that condemns feelings or manifestations of sexual orientation and gender identity that differ from the heterosexual convention. Especially damaging are efforts to “undo” a young person’s sexual orientation through “reparative” or “conversion” therapies (GLMA 2001).

**Low SES:** According to one recent study, unemployment, poverty, and housing unaffordability were correlated with a risk of mental illness. The poorer a person’s socioeconomic conditions, the higher his or her risk for mental disability and psychiatric hospitalization, regardless of what economic hardship or type of mental illness the person suffered (Hudson 2005).

Understanding the connections between mental illness and tobacco use is an emerging area of research in which more work needs to be done.

### **Disparities in access to health care**

Disparities in health status are at least partly related to differences in access to health care services. Access is a broad concept: it includes issues such as the quality of interactions with health care professionals, appropriate diagnosis and treatment, health insurance coverage, geographical location of facilities, and transportation barriers. In its 1999 report on health disparities, the U.S. Commission on Civil Rights found that racial and ethnic bias in health care systems manifests in a variety of ways, including differences in the delivery of health services; inability to access health services because

of lack of financial resources; culturally incompetent health care providers; language barriers; the unavailability of services; and exclusion from health-related research (U.S. Commission on Civil Rights 1999).

### **A lack of cultural competency**

Researchers have discovered that, while unintentional, health care providers make treatment decisions based on their cultural and racial biases and stereotypes and directly contribute to racial disparities in health care and health outcomes. Providers communicate lower expectations for patients of color and poor patients, including a lower expectation of medical resources and assistance; lower expectations of improvement in their medical condition; and disparaging or dismissive views concerning family and social support necessary to aid in or support recovery (U.S. Commission on Civil Rights 2004). Disrespect for economically deprived patients or for those from racial or ethnic minority groups occurs when patients are called by their first names without asking if this is their preference or when they are kept waiting for long periods of time. Leaving inadequate time to answer patients' questions and a generally hurried and hassled atmosphere also convey negative provider attitudes (Klerman 1992).

Culture and language can act as barriers to quality health care. A lack of information about the need for care may be the result of an inability to speak or read English. Non-English speakers have found their access to medical care blocked by forms that have not been translated into other languages or the absence of staff to assist non-English-speaking patients. Patients with strong ties to other cultures—including some American Indians and Alaska Natives, Hispanics/Latinos, and recent Asian immigrants—may find the American medical system alien to them (Klerman 1992).

Disparities extend beyond race and ethnicity: the LGBT community also faces discrimination and bias in medical encounters. LGBT people are likely

to receive substandard care, or to remain silent about important health issues they fear may lead to stigmatization. Medical forms and the formats of medical intake and history are often insensitive to the experience of LGBT patients, and likely to discourage disclosure of sexual orientation and behavior. Treatment modalities that rely on group therapies and support groups are also vulnerable to the effects of discrimination, with participants often forming a justifiable fear that full disclosure of personal details may adversely affect their standing in the group or health care setting. LGBT people report discriminatory treatment following disclosure of sexual orientation in paramedical and auxiliary care settings, including nursing homes, domestic violence centers, senior centers, and others. Prejudice against transgendered individuals is pervasive within American medicine. Most U.S. medical providers and researchers, as well as the public at large, believe that transgendered behavior is pathological; this in itself constitutes one of the most significant barriers to care. As a result, transgendered individuals underutilize medical and social services (Dean et al. 2000).

### **Disparities in diagnosis and treatment**

According to the IOM, disparities in medical treatment are well documented; issues of access to quality care, access to specialists, unequal treatment, and disparities in diagnosis all contribute to these disparities. For example:

- Although ethnic and racial minorities have a much higher rate of death and illness from diabetes, the disease is poorly managed among minority patients. In one study of Medicaid patients, minority diabetic patients were found less likely to receive key diagnostic tests, and more likely to receive less-desirable procedures, such as lower limb amputations for diabetes and other conditions.
- There are significant racial differences in cancer diagnostic tests and treatments. For example, Hispanic/Latina women who were newly diagnosed with lung or breast cancer were diagnosed in later stages and had lower survival

rates than White women with similar conditions.

- Although African Americans suffer strokes at much higher rates than Whites do, several studies have found that they are less likely to receive major diagnostic and therapeutic interventions.
- Minorities are less likely to be placed on waiting lists for kidney transplants or to receive kidney dialysis or transplants.
- Minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery.
- Asthmatic African-Americans are less likely than their White counterparts to receive appropriate medications to manage chronic symptoms (IOM 2002).

### **Disparities in insurance coverage**

An important element in health care access is health insurance coverage. Over twenty percent of Californians have no health insurance, placing California in the top five states ranked by proportion of uninsured. Among ethnic and racial groups, Hispanics/Latinos have the highest rate of uninsurance at 28 percent, and also have the lowest rate of job-based insurance at 42 percent. Among women, 45 percent of Hispanics/Latinas and 26 percent of Asian and Pacific Islander women are uninsured, compared to 15 percent of White women (Lincoln and Ong 2001).

Even in situations where people have health insurance, the working poor and middle class often do not have coverage for their families. Another barrier to access is the fear that immigrant families face—even legal immigrants—of stigma and discrimination when seeking health care (Prevention Institute and APHA 2003).

There is systemic bias against LGBT people in health insurance and public entitlements, which routinely fail to cover gay and lesbian partners or provide reimbursement for procedures of particular relevance to LGBT populations. Transgendered persons frequently experience social and economic marginalization. Those rejected by family and

community and with reduced education and employment opportunities because of harassment and discrimination commonly experience unemployment, poverty, and homelessness. Unemployment and underemployment result in no or inadequate health insurance, thus many transgendered persons are unable to afford basic medical and mental health services. A disproportionate number of these individuals are people of color, HIV-positive people, or youth, thereby increasing the likelihood that they are socially marginalized and medically underserved. For transgendered people who have health insurance, public and private insurers often specifically exclude coverage on the grounds that treatments are either cosmetic or experimental. Transgendered individuals, even when they receive a formal psychiatric diagnosis such as gender identity disorder, are denied the legal protection that such a diagnosis ordinarily provides (Dean et al. 2000).

### **Nonfinancial barriers**

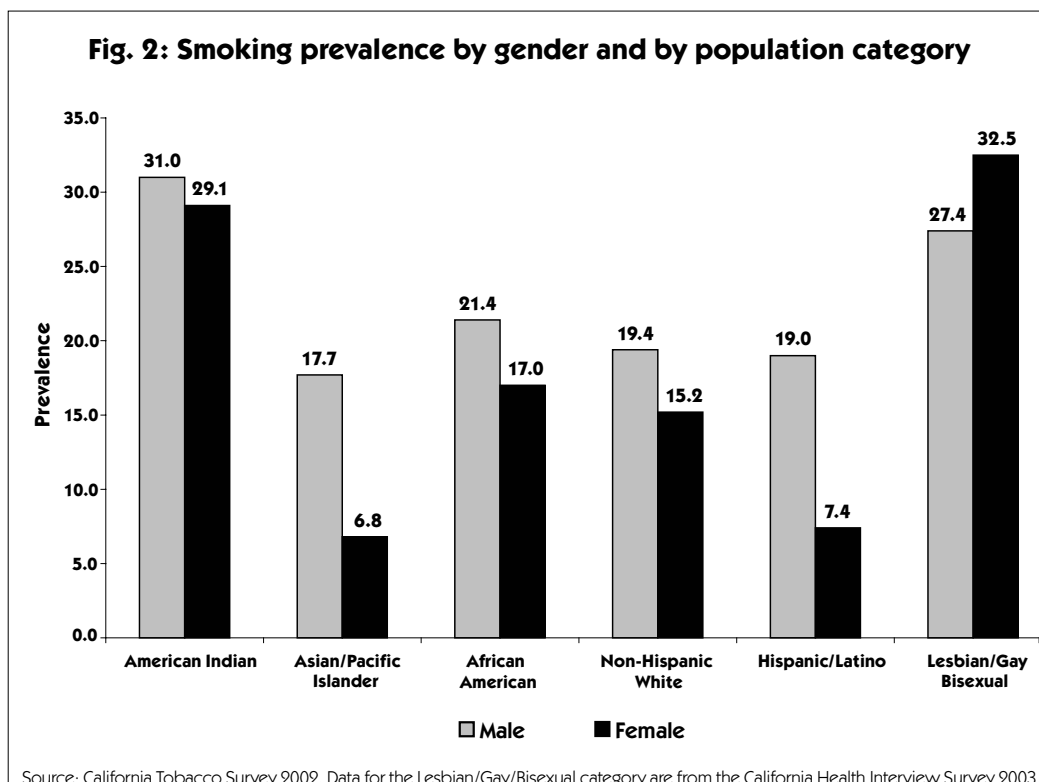
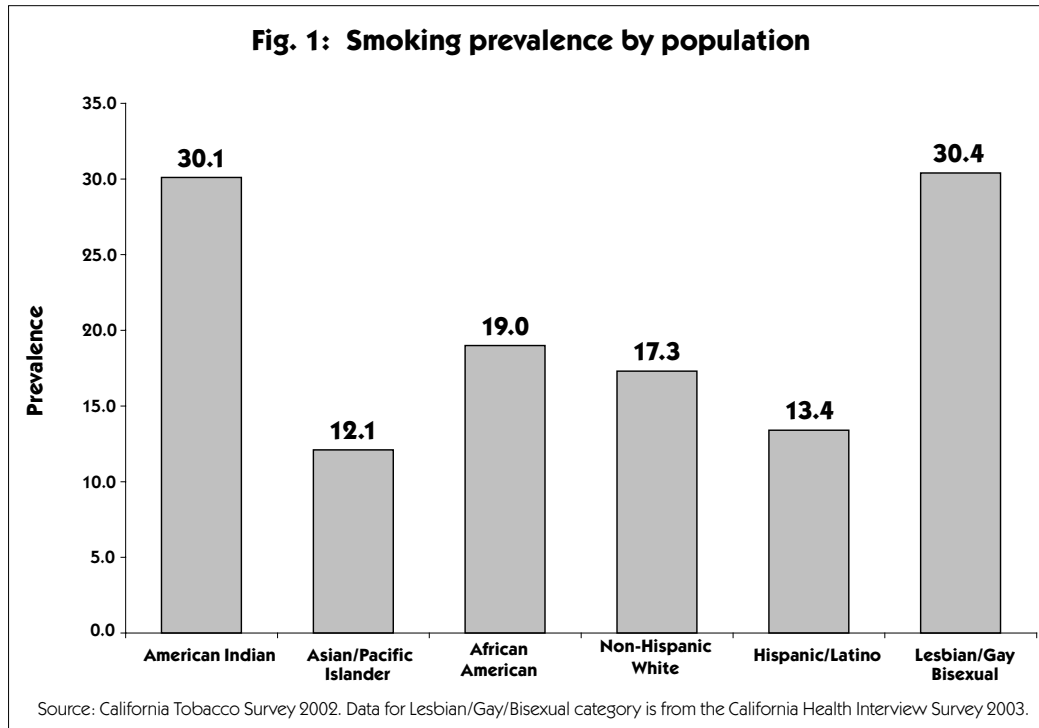
Nonfinancial barriers to quality medical care include geographic inaccessibility, lack of transportation, long waiting times at clinics, inconvenient hours, and fear associated with immigration status. Geographic and transportation issues include those that are caused by inadequate numbers of providers relative to the population in a specific area and those that result from large distances between patients and providers in rural or nonmetropolitan areas. Generally, physicians are concentrated more heavily in high income neighborhoods within metropolitan areas, leaving low income inner-city neighborhoods and rural communities with fewer practitioners.

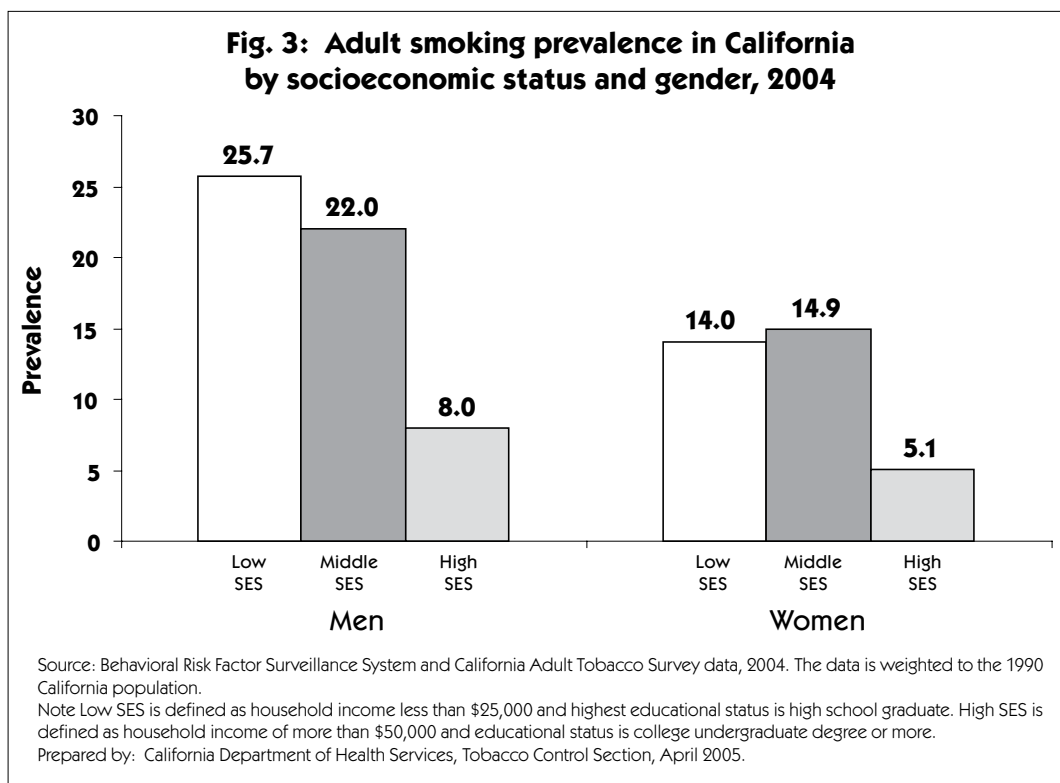
The inappropriate use of the hospital emergency room is a symptom of access issues for low income patients, who often face barriers to receiving care at primary care facilities. Barriers such as difficulty getting appointments with providers, long wait times until patients can be seen, and clinics' limited hours of operation prompt many low income people to use the emergency room in place of a primary care facility (Klerman 1992).

# The many aspects of tobacco-related disparities

Tobacco-related disparities encompass issues of prevalence, exposure to secondhand smoke, tobacco industry targeting, and communities'

capacities to address tobacco-related challenges. As a result, high prevalence rates are found in several communities of color and the LGBT community, as shown in Figure 1. Within population groups, smoking prevalence often varies considerably between men and women, as shown in Figure 2.





Smoking prevalence is greater in low socioeconomic groups than in high socioeconomic groups, as shown in Figure 3.

In addition to smoking prevalence, exposure to secondhand smoke is a significant issue in communities of color, the LGBT community, and the Low SES community. For example, relatively high rates of exposure to secondhand smoke occur among people working in the building trades and other blue collar occupations (BUILT 2001).

Because of the disparities in access to health care discussed earlier, differences exist in the abilities of priority populations to access culturally appropriate cessation services. In addition, little research and funding are available to support resources for smoking cessation and prevention strategies that effectively target the Low SES population, and many tobacco education materials and programs are not culturally or linguistically appropriate for Low SES populations (Advocacy Institute 2001).

Higher tobacco use in priority populations is also related to disproportionate targeting by the tobacco industry. The tobacco industry advertises heavily in a variety of ethnic magazines and LGBT publications, sponsors ethnic and LGBT cultural and community events, and makes contributions to higher education institutions, candidates and elected officials, civic and community organizations, and scholarship programs that serve priority populations (U.S. Surgeon General 1998; Cruz and Islam 2005). Priority populations need assistance in finding funds and other resources to replace those supplied by the tobacco industry.

Finally, in order for priority populations to adequately address the burden of tobacco within their own communities, disparities within the tobacco control infrastructure need to be addressed. Further research into the particular needs of each priority population and their diverse subgroups is warranted, and tobacco control organizations must ensure appropriate

representation and participation in addition to adequate funding in all areas of decision-making, strategic planning, and program development.

## **Finding common ground: Similarities among priority populations**

Notwithstanding the distinct differences within and between priority populations, many commonalities do exist. For example, many of the priority populations are targets of intense community-specific marketing strategies by the tobacco industry; in each population, the fierce competition for resources often relegates tobacco control issues to a lower priority; and priority populations often perceive a shortage of culturally-competent cessation services.

Other points of commonality include the following:

- Protection of youth and family is a common theme.
- Respect for elders is a strong cultural value in several priority populations.
- The addictive nature of tobacco makes the translation of awareness to action extremely difficult.

- There is a lack of awareness within priority populations of how the tobacco industry targets these communities or denial that this marketing has any effect.
- It is best to avoid having “outsiders” come into a community and tell people what to do.
- Language issues often present challenges; simply translating materials from one language to another is often not effective.
- Linking tobacco issues to other existing issues in priority population communities is an important strategy.
- Finding and applying for funding from various agencies and organizations can be difficult.
- For groups that have accepted tobacco industry money in the past for publications, projects, organizations, and events, there is a need for assistance in finding alternative sources of funding.

(Source: CDHS/TCS Key Informant Interviews 2002)

## Resources – Section 1

There are literally thousands of resources on the Internet related to socioeconomic and health disparities. The following sites are recommended starting places:

Advocacy Institute, [www.advocacy.org](http://www.advocacy.org)

American Public Health Association  
[www.apha.org](http://www.apha.org)

California Department of Health Services  
Office of Multicultural Health  
<http://www.dhs.ca.gov/director/omh/>

Economic Policy Center, [www.epinet.org](http://www.epinet.org)

Health Education Council  
[www.healthedcouncil.org](http://www.healthedcouncil.org)

National Network on Tobacco Prevention and Poverty, [www.nntpp.org](http://www.nntpp.org)

Public Policy Institute of California  
[www.ppic.org](http://www.ppic.org)

U.S. Centers for Disease Control, Office of Minority Health, [www.cdc.gov/omh/](http://www.cdc.gov/omh/)

U.S. Commission on Civil Rights  
<http://www.usccr.gov/>

U.S. Department of Health and Human Services,  
Office of Disease Prevention and Health Promotion, Healthy People 2010  
[www.healthypeople.gov/](http://www.healthypeople.gov/)

U.S. Department of Health and Human Services, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, “Culture, Race and Ethnicity — A Supplement to Mental Health: A Report of the Surgeon General,” fact sheet,  
<http://www.surgeongeneral.gov/library/mentalhealth/cre/fact.asp>.

## References – Section 1

Advocacy Institute. 2001. Special Populations: Implications for State Tobacco Policy. Washington, D. C. An online publication available at <http://www.advocacy.org/publications/mtc/specialpopulations.htm>

Prevention Institute and American Public Health Association (APHA). 2003. Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities, a publication of the California Campaign to Eliminate Racial and Ethnic Disparities in Health. Washington, D.C.: American Public Health Association. Available at <http://www.apha.org> and <http://www.preventioninstitute.org/healthdis.html>

Badgett, M. V. L. 1998. Income Inflation: The Myth of Affluence among Gay, Lesbian, and Bisexual Americans. The Policy Institute of the National Gay and Lesbian Task Force and The Institute for Gay and Lesbian Strategic Studies. Available at <http://www.nglft.org>

BUILT (Building Trades Unions Ignite Less Tobacco). Undated. Untitled brochure. Available online at <http://sbctc.org/pdf/built%20brochure.pdf>

California Department of Finance. See State of California Department of Finance.

California Department of Health Services, Center for Health Statistics, Office of Health Information. 2003. Multicultural Health Disparities. Available at <http://www.dhs.ca.gov/hisp/chs/OHIR/Publication/OtherReports/MHD051703.pdf>

California Department of Health Services, Tobacco Control Section. May 26, 2004. Press Release: California's Adult Smoking Declines to Historic Lows. Available at <http://www.dhs.ca.gov/tobacco/documents/press/PressRelease5-26-04.pdf>

CDC. See U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics.

CDHS/Center for Health Statistics. See California Department of Health Services, Center for Health Statistics, Office of Health Information.

CDHS/TCS. See California Department of Health Services, Tobacco Control Section.

Cheng, J. Y. 2001. At Home and in School: Racial and Ethnic Gaps in Educational Preparedness, in California Counts: Population Trends and Profiles. San Francisco, California: Public Policy Institute of California.

Cruz, T. B., and S. Islam. 2005. Targeting of Specific Populations by the Tobacco Industry. Alhambra, California: University of Southern California Press.

Dean, L., I. H. Meyer, K. Robinson, R. L. Sell, R. Sember, V. M. B. Silenzio, D. J. Bowen, J. Bradford, E. Rothblum, J. White, P. Dunn, A. Lawrence, D. Wolfe, and J. Xavier. 2000. Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns. *Journal of the Gay and Lesbian Medical Association* 4(3). Available online at <http://www.glma.org/pub/jglma/vol4/3/index.html>

Economic Policy Institute, Center on Budget and Policy Priorities. 2002. Pulling Apart: A State-by-State Analysis of Income Trends. Available online at [http://www.epinet.org/content.cfm/studies\\_pullingapart](http://www.epinet.org/content.cfm/studies_pullingapart)

Gay and Lesbian Medical Association. 2001. Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health. San Francisco, California: Gay and Lesbian Medical Association. Available online at [http://www.glma.org/policy/hp2010/PDF/Mental\\_Health.pdf](http://www.glma.org/policy/hp2010/PDF/Mental_Health.pdf)

GLMA. See Gay and Lesbian Medical Association.

Hood, E. 2005. Dwelling disparities: how poor housing leads to poor health. *Environmental Health Perspectives* 113(5):A290-1.

Hudson, C. 2005. Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection. *American Journal of Orthopsychiatry* Vol. 75, No. 1.

IOM. See U.S. Department of Health and Human Services, Institute of Medicine, Board on Health Sciences Policy.

Klerman, L. V. 1992. Nonfinancial Barriers to the Receipt of Medical Care. *U.S. Health Care for Children. The Future of Children*, Winter 1992. Available at [http://www.futureofchildren.org/usr\\_doc/vol2no2ART11.pdf](http://www.futureofchildren.org/usr_doc/vol2no2ART11.pdf)

Lincoln, J. and P. Ong, ed. 2001. The State of California Labor. A publication of the UC Institute for Labor and Employment. Berkeley, California: University of California Press. Available online at <http://www.iir.ucla.edu/scl/pdf01/scl2001overview.pdf>

Lopez, A. 2002. Race and Poverty Rates in California: Census 2000 Profiles. Palo Alto, California: Center for Comparative Studies in Race and Ethnicity, Stanford University. Available online at [http://www.stanford.edu/dept/csre/reports/report\\_12.pdf](http://www.stanford.edu/dept/csre/reports/report_12.pdf)

Office of Minority Health(a), citing CDC statistics, refers to the following United States Department of Health and Human Services Web page: <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=23>

Office of Minority Health(b), citing CDC statistics, refers to the following United States Department of Health and Human Services Web page: <http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=4>

Ong, P. M., with H. G. Sung, A. M. Uchida, and J. Heintz-Mackoff. 2004. American Indian Adults in Los Angeles, California, and the U.S. Los Angeles, California: United American Indian Involvement and the UCLA Ralph and Goldy Lewis Center for Regional Policy Studies. Available online at <http://lewis.sppsr.ucla.edu/publications/policybriefs/AIANAdultReport1.pdf>



NAMI. See National Alliance for the Mentally Ill.

National Alliance for the Mentally Ill fact sheet: African American Community Facts about Mental Health. Available at [http://www.nami.org/Content/ContentGroups/Multicultural\\_Support1/AA\\_Facts\\_05.pdf](http://www.nami.org/Content/ContentGroups/Multicultural_Support1/AA_Facts_05.pdf)

National Alliance for the Mental Ill fact sheet: Latino Community Mental Health Facts. Available at [http://www.nami.org/Content/ContentGroups/MIO/Fact\\_Sheets1/Latino\\_MH\\_Disparities\\_2003.pdf](http://www.nami.org/Content/ContentGroups/MIO/Fact_Sheets1/Latino_MH_Disparities_2003.pdf)

Pamuk, E., D. Makuc, K. Heck, C. Reuben, and K. Lochner. 1998. Socioeconomic Status and Health Chartbook. Health, United States, 1998. Hyattsville, Maryland: National Center for Health Statistics.

Prevention Institute and American Public Health Association (APHA). 2003. Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities, a publication of the California Campaign to Eliminate Racial and Ethnic Disparities in Health. Washington, D.C.: American Public Health Association. Available at <http://www.apha.org> and <http://www.preventioninstitute.org/healthdis.html>

Public Policy Institute of California. Summary of the following document: Citrin, J., and B. Highton. 2002. How Race, Ethnicity, and Immigration Shape the California Electorate. Available online at [www.ppic.org/content/pubs/R\\_1202JCR.pdf](http://www.ppic.org/content/pubs/R_1202JCR.pdf).

Reich, M., and P. Hall. 2001. Chapter 6: A Small Raise for the Bottom. In Lincoln, J. R. and P. Ong, ed. The State of California Labor. A publication of the UC Institute for Labor and Employment. Berkeley, California: University of California Press. Available online at <http://www.iir.ucla.edu/scl/pdf01/scl2001ch6.pdf>

Reyes, B. I., ed. 2001. A Portrait of Race and Ethnicity in California: An Assessment of Social and Economic Well-Being. San Francisco, CA: Public Policy Institute of California. Available online at [http://www.ppic.org/content/pubs/R\\_201BRR.pdf](http://www.ppic.org/content/pubs/R_201BRR.pdf)

State of California, Department of Finance. 2004. Population Projections by Race/Ethnicity, Gender and Age for California and Its Counties 2000-2050. Sacramento, California. Available at [http://www.dof.ca.gov/HTML/DEMOGRAP/DRU\\_Publications/Projections/P3/P3.htm](http://www.dof.ca.gov/HTML/DEMOGRAP/DRU_Publications/Projections/P3/P3.htm).

State of California Department of Finance, Demographic Research Unit. 2001. Data available at <http://www.dof.ca.gov/HTML/DEMOGRAP/Druhpar.htm>.

U.S. Commission on Civil Rights. 1999. The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality. Washington, D. C.

U.S. Commission on Civil Rights. 2002. A New Paradigm for Welfare Reform: The Need for Civil Rights Enforcement, A Statement by the U.S. Commission on Civil Rights. Available online at <http://www.usccr.gov/>

U.S. Commission on Civil Rights. 2004. Broken Promises: Evaluating the Native American Health System. Available at <http://www.usccr.gov/pubs/nahealth/nabroken.pdf>

USDHHS Healthy People 2010. See U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

U.S. Department of Health and Human Services, Center for Disease Control and Prevention (CDC), National Center for Health Statistics. 2005. Health, United States, 2005. Available at <http://www.cdc.gov/nchs/hus.htm>.

U.S. Department of Health and Human Services,  
Office of Disease Prevention and Health Promotion.  
Healthy People 2010. Available online at [www.  
healthypeople.gov/](http://www.healthypeople.gov/)

U.S. Department of Health and Human Services,  
Institute of Medicine, Board on Health Sciences  
Policy. 2002. Unequal Treatment: Confronting  
Racial and Ethnic Disparities in Health Care.  
Washington, DC.: National Academies Press.  
Available at [http://www.nap.edu/catalog/10260.  
html?onpi\\_newsdoc03202002](http://www.nap.edu/catalog/10260.html?onpi_newsdoc03202002).

U.S. Surgeon General. 1998. Factors that Influence  
Tobacco Use Among Four Racial/Ethnic Minority  
Groups, in Tobacco Use Among U.S. Racial/Ethnic  
Groups. Available online at [http://www.cdc.gov/  
tobacco/sgr/sgr\\_1998/sgr-min-pdf/chap4.pdf](http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-pdf/chap4.pdf)

# Section 2: Tobacco Control Issues in the African American Community

## Key Points

- In 2002, the smoking prevalence rate among adult African Americans in California was 19.0 percent.
- The smoking prevalence rate among African American youth is relatively low, but the smoking rate increases dramatically for young African Americans in the years just following high school.
- There is a need for cultural competency training for mainstream tobacco control staff, and tobacco control materials need to be revised to speak to the needs of African American consumers.
- The tobacco industry markets heavily to the African American community, has infiltrated the worlds of African American business and politics, and buys support of the community through extensive sponsorship of cultural, educational, and entertainment events.
- There are many potential collaborative partners in the African American community.
- Cultural values of importance to the African American community include respect, honesty, and the role of the family.
- African Americans bear the greatest health burden of disease and death by cigarette smoking of any ethnic or racial group.
- African Americans perceive a need for greater access to culturally competent tobacco cessation services.

Smoking prevalence is higher in California's African American community than in the state's population as a whole. Possible factors include intense marketing by the tobacco industry, societal factors such as stress and the use of tobacco in social settings, and a shortage of culturally-competent cessation services.

The information in this section was collected from focus group interviews conducted in 2002, key informant interviews conducted by CDHS/TCS in 2003, statistical reports available as of mid-2006, and literature searches conducted in 2004, 2005, and 2006. All of the quotes in this section are excerpts from the 2003 key informant interviews. Much of the discussion that follows reflects the diverse opinions

and perceptions of focus group participants and key informants, and should not be assumed to reflect in its entirety the views of CDHS/TCS.

## What is the smoking prevalence rate in California's African American community?

In 2002, the most recent year for which data are available, the smoking prevalence rate among California's adult African Americans was 19.0 percent, with 17.0 percent of African American women and 21.4 percent of African American men reported to be smokers (California Tobacco Survey 2002).

While smoking rates among African American adults are higher than among California's population as a whole, smoking rates among African American high school youth are relatively low compared to other ethnic and racial groups. In 2004, 7.2 percent of African American high school youth had smoked within the past 30 days, compared to 15.8 percent of non-Hispanic Whites (California Student Tobacco Survey 2004). The years just following high school are critical in terms of tobacco control: African Americans are relatively more likely than other ethnic and racial groups to initiate smoking as young adults between the ages of 18 and 21 (California Tobacco Survey 2002).

## Who is California's African American community?

California's 2.5 million African Americans constitute almost 7 percent of the state's population (U.S. Census Bureau 2000). In comparison, African Americans represent 13 percent of the total U.S. population (U.S. Census Bureau 2002).

When working with the African American community, it is important to recognize the diversity that exists within this community, including:

- Socioeconomic status (including educational attainment)
- Religious affiliation
- Age
- Country of origin or culture (e.g., African and Caribbean immigrants)

## In what ways have mainstream tobacco control efforts failed to address the needs of the African American community?

According to focus groups conducted in 2002 and key informant interviews conducted in 2003

by the California Department of Health Services/ Tobacco Control Section (CDHS/TCS), many African Americans perceive mainstream tobacco control efforts in their community to suffer from these shortcomings:

- Not enough funding is slated for tobacco control in the African American community, especially in light of the disproportionate rate of smoking among African American men and the huge dollar amount the tobacco industry spends in the community.
- Statewide anti-tobacco media campaigns aimed at African Americans are failing to convey the anti-tobacco message to some of the people who need to hear it.<sup>1</sup>
- Tobacco control workers from outside the African American community are not well equipped to work with African Americans. There is a great need for cultural competency training among non-African Americans.
- Tobacco control programs in the African American community need to use more innovative materials that depict African American individuals and families, are designed with bright Afrocentric colors, and feature text that reflects the African American experience.
- African Americans perceive a disparity in the enforcement of tobacco control laws in their neighborhoods as compared to other neighborhoods.
- Access to culturally competent, affordable, convenient cessation services is extremely limited.

## How does the tobacco industry target the African American community?

The tobacco industry markets heavily to the African American community with specific products, advertising campaigns, and advertising placement that directly targets African American neighborhoods. Some products are marketed exclusively or primarily to African Americans (e.g.,

<sup>1</sup> CDHS/TCS has launched anti-tobacco media campaigns in a variety of media formats focused on the African American community every year since 1990.

Black and Mild cigars, and certain brands of menthol cigarettes such as Kool). Most troubling is the fact that many pro-tobacco images are aimed at youth in African American neighborhoods and through youth-oriented media outlets, concerts, and events.

In addition, the tobacco industry has infiltrated the worlds of African American business, entertainment, and community organizations. A study done by Michael Siegel at the Boston University School of Public Health that explored tobacco industry sponsorship in the years 1995 to 1999 identified four tobacco industry sponsorships targeted at minority groups in general (Siegel 2000):

- The Consortium for Graduate Study in Management Fellowships for Talented Minorities, which is awarded on the basis of merit to African American, Hispanic American, and Native American college graduates pursuing a graduate degree in business;
- The INROADS program, which consists of high school instructional programs and college internships aimed at helping to develop and place minority youth in business and industry;
- The Multicultural Alliance, which provides teaching fellowships to African Americans, Latinos, and Asian Americans to address the shortage of people of color in the teaching profession; and
- Fellowships for Artists of Color at the Yale School of Art, California Institute of the Arts, Cranbrook Academy of Art, Maryland Institute College of Art, and the School of the Art Institute of Chicago.

This study further identified several sponsorships targeted at the African American community in particular, including the following:

- Ethnic festivals (African American Cultural Expo, Indiana Black Expo, and National

Black Arts Festival)

- Art exhibitions featuring African American artists
- Dance companies (Alvin Ailey American Dance Theater and the Dance Theater of Harlem)
- National organizations (such as the National Convention of the National Black Chamber of Commerce)
- The S.E.E.D. Scholars Program, which provides college scholarships to African American students
- The Black Collegian Online, an Internet magazine serving African American collegians and all people of color seeking career advancement and personal development

More recently, the Tobacco Industry Monitoring Evaluation (TIME) project of the University of Southern California found that in 2002-2003, recipients of tobacco industry money in California included the 100 Black Men of America, the Congressional Black Caucus Foundation, the National Black Chamber of Commerce, and the National Urban League (TIME Project 2004). Such contributions buy the goodwill of the community and make tobacco control work difficult and adversarial.

In an interview in the September 30, 2003 edition of the Tobacco Technical Assistance Consortium's online publication ttac exchange, Valerie Yerger and Ruth Malone of the Center for Tobacco Control Research and Education, University of California,

San Francisco described how tobacco

industry documents reveal the myriad ways the industry

targets the African American community through sponsorship. They found that the tobacco industry established relationships with virtually every African American leadership organization and built longstanding social connections with the community for three

**I don't like to use the words "scare tactics," but my people want to know the truth; don't camouflage the effects. People need to know the facts if they are going to try doing something about [tobacco use] either personally or at the community level.**

Beverly Jones-Wright,  
San Bernardino County Dept. of Public Health

specific business reasons: to increase African American tobacco use, to use African Americans as a frontline force to defend industry policy positions, and to defuse tobacco control efforts.

According to Yerger and Malone, “Black opinion leaders were researched and sought out by the tobacco industry in order to enhance corporate image and improve market position within African American communities. One industry image-building strategy was to establish an association with the public service efforts of African American organizations. For example, industry documents describe a Philip Morris-sponsored symposium focusing on blacks and their civil rights struggle. Tobacco money supported African American civil, educational, social, and political organizations and community leaders elected on local, state, and federal levels. Support included corporate contributions, business expenses, honoraria, journal ads, and promotional items. The amount of support was based on the degree to which the organization was important to the future of [Philip Morris]. In 1989, 70 percent of Phillip Morris’s expenditures to minority organizations went to black groups. The industry extracted something in return from organizations that received its money.”

According to several key informants interviewed by CDHS/TCS, the influence of the tobacco industry is clear in publications such as *Ebony*, *Jet*, and *Essence* (major African American magazines) that refuse to publish tobacco control advertising or articles discussing the negative effects of tobacco use. These publications contribute to the social norm that tobacco use is acceptable.

One African American tobacco control advocate noted that industry influence is becoming more local and more difficult to track. The many ways in

which the industry involves itself at the local level is becoming more subtle and harder to identify until an event actually happens.

Tobacco company Web sites provide several examples of this subtle industry influence. Altria, the parent company of Philip Morris, describes the company’s “Know Your Money” program on its Web site:

“The Altria family strives to play a role in contributing to the prosperity and enrichment of the communities where its companies conduct their activities. As part of that commitment, in 2002, Altria and the National Urban League launched a collaborative effort designed to provide young African American professionals (ages 21-35) with strategies for effective money management. The program was developed in response to national research commissioned by Altria that identified the need for economic empowerment as a critical community concern” ([http://www.altria.com/download/pdf/media\\_Programs\\_and\\_Partnerships\\_White\\_Paper.pdf](http://www.altria.com/download/pdf/media_Programs_and_Partnerships_White_Paper.pdf)).

On its Web site, RJReynolds advertises its philanthropic efforts in the African American community, including The National Black Theatre Festival, the National Urban League, the North Carolina Black Repertory Company, and the Winston-Salem Urban League (<http://www.rjrt.com/IN/COLegacy.asp#ContLegacy>).

## **How can local tobacco control programs identify and reach out to African American gatekeepers and collaborative partners?**

One of the challenges in conducting tobacco control activities in African American communities, as in many communities, is to find collaborative

**There are strong community and organizational ties to the tobacco industry. It’s too close for comfort.**

Sule Gordon, Council for Responsible Public Investment

partners. Unfortunately, community representatives say that the ties between Black leadership and the tobacco industry can be “too close for comfort.” Tobacco control agencies and coalitions must seek out gatekeepers—individuals and organizations known in the community who can help “outsiders” gain access and trust.

Tobacco control experts and other representatives from the African American community suggested looking to these groups and individuals to form partnerships and to use as resources:

- African American doctors, nurses, and other health care providers
- Staff at programs that may have interests in common, such as the Black Infant Health Program
- State and national tobacco control projects such as the African American Tobacco Education Partnership and the National African American Tobacco Education Network
- Urban League
- Faith leaders (but only after they have been educated on the issue)

## How can tobacco control materials and activities be made more culturally competent for the African American community?

Representatives of the African American community suggested the following guidelines:

- Think beyond the brochure. Use TV and radio, and take advantage of more interactive media such as compact discs (CDs) and Web sites.
- Use celebrities in anti-tobacco materials to counter the strong presence of the tobacco industry in Black entertainment.
- Materials need to be much better. They

need to be attractively packaged, have bright colors, display African American images, and be more “hard-edged.”

- Most importantly, get community input and hire African American staff.

## What are some ways to effectively communicate anti-tobacco messages to the African American community?

For a variety of reasons, tobacco control issues are not always seen as high priority issues facing the African American community. Community representatives say that, with more education, interest in tackling this issue would increase.

Key informants suggested that, when planning tobacco control programs in the African American community, tobacco control advocates should keep the following in mind:

- Respect is paramount. It is important to listen to input and then act upon it. The community is quick to see when its input is not valued or used. Community members react negatively to being asked merely to respond to or act as “rubber stamps” for the ideas or activities of others.
- Many African Americans feel strongly that the solutions to their issues, including tobacco control issues, must come from within the community and not from outside of it. Outside agencies must be flexible and support community-driven intervention ideas.

**You  
need to invest  
in the community  
and become a part of the  
community, even if that means  
you participate in programs that  
have nothing to do with tobacco.**

Vashron Chapple, National African American Tobacco Education Network

- When a clear connection is made between tobacco control needs and other issues of importance to the community (protecting youth, heart disease, helping pregnant women), interest in tobacco control increases significantly. There is definite interest in collaborating with other minority groups on

the issues of tobacco control, as long as the distinctions between the needs of the various groups are not lost in the process.

- Tobacco control programs need to address African American-specific issues such as menthol cigarettes, flavored cigarettes, and blunts (marijuana in cigar wrappers).
- Have the family as a focus: “Be around for your children and grandchildren.”
- Promote youth advocacy. Youth can bring the issue to community leaders and policymakers. They have a lot of energy and will involve others in their policy-making efforts.
- Include African American smokers in planning and programming.
- Smoking needs to be de-glamorized in the African American community.

## What specific kinds of tobacco control messages might resonate with the African American community?

Representatives of the African American community cited three subject areas from which to draw powerful tobacco control messages: health, secondhand smoke, and social justice.

### Health

According to the United States Surgeon General, African Americans bear the greatest health burden of disease and death by cigarette smoking of any ethnic or racial group (U.S. Surgeon General 1998). Yet, there is a certain amount of complacency,

skepticism, and even denial about the health consequences of tobacco smoke within the Black community. For some, the consequences are simply too far in the future to worry about, or the progress of disease too slow to notice on a daily basis.

**Include African Americans who are smokers when you are addressing the community and planning programs. Smokers hate to be left out of the process. They would prefer to help develop and tailor the program that is meant for them.**

Statice Wilmore, City of Pasadena Health Department

Even so, the health consequences are dire: in terms of tobacco-related diseases, heart disease and cancer are the leading causes of death among African Americans (USDHHS/NIH 2004). In addition, African American men have a higher lung cancer death rate than White, Hispanic/Latino, Asian American, or American Indian men (U.S. Surgeon General 1998).

In California in 2004, the age-adjusted lung cancer death rate for African Americans was 53.4 per 100,000 people, while the rate for non-Hispanic Whites was 47.7 (CDHS/CHS/OHIR 2001).

Community representatives say that the myriad health concerns of the African American community provide opportunities to link tobacco use to other health issues, such as alcohol consumption, diabetes, nutrition, and exercise.

Both the content of the message and the identity of the messenger are important. Because of historical and present-day health care disparities, some African Americans harbor a deep-seated mistrust of the mainstream American health care system. Although it is tempting to focus primarily on African American health care providers as messengers, it is important to remember that African American patients are seen by health care practitioners of all races; therefore, the medical community must be addressed broadly on these issues.



## Secondhand Smoke

More education is needed in the community about the dangers of secondhand smoke, especially for children. In 2002, 27 percent of African American youth in California (19.0 percent of African American boys and 35.4 percent of African American girls) reported being in the same room at home during the previous week with someone who was smoking cigarettes (California Student Tobacco Survey 2002). However, African American parents are working to protect children from secondhand smoke exposure at home. In 2002, the percent of African American households that had children or adolescents with a total ban on smoking in the home reached 78.4 percent (California Tobacco Survey 2002).

High rates of smoking and secondhand smoke exposure contribute to a high prevalence of asthma in the African American community. Among African Americans, one in five children and one in six adults have been affected by asthma, rates far higher than those for Hispanics/Latinos, Asian Americans, and White Californians (Brown et al. 2002), and in 2000, African Americans were hospitalized for asthma three times more than other ethnic groups (Stockman et al. 2003).

The community can point to a few successful programs at work on this issue, such as the American Lung Association in Santa Clara County working with the Black Infant Health Program to educate parents and parents-to-be about the relationship between secondhand smoke and the increased incidence of asthma, chronic bronchitis, and ear infections.

## Social Justice & Anti-Tobacco Industry Messages

Social justice messages can be extremely powerful in the African American community. Opportunities exist to link tobacco to the history of slavery, oppressive working conditions, overt and covert discrimination, the tobacco industry's disrespect for the community, and unjust disparities in the health care system.

**The tobacco industry's targeting of our communities is a social justice issue. We need to be honest and address leadership. Folks need to be accountable to the community for their actions to the community.**

Beverly Jones-Wright, County of San Bernardino Dept. of Public Health

In addition, African Americans need to become more aware of the influx of tobacco industry money into the community and its corrupting influence on the community's business, cultural, and political leadership.

Beyond awareness, there is an urgent need to identify strategies for working with organizations and community endeavors that take tobacco industry money. Many in the African American community are ambivalent or in favor of taking money from the tobacco industry. Some see it as an appropriate use of money that the industry has taken out of the community and do not see the negative consequences for doing so. Effective strategies for countering these perceptions need to be developed.

Disparate enforcement of youth access laws in African American neighborhoods can also be seen as a social justice issue. The community must demand better enforcement by its local officials, as well as take more responsibility for notifying merchants when youth are able to purchase tobacco from them.

## What barriers and competing issues make it difficult to elevate the importance of tobacco control within the African American community?

Issues competing for attention with tobacco control in the African American community include

- Crime
- Violence
- Liquor control
- Disintegration of the family
- Health issues such as diabetes, heart disease, stroke, and obesity
- Basic economic survival
- Drugs and alcohol
- HIV/AIDS

Several community representatives mentioned their perception that youth access to tobacco remains a problem in African American communities, and that only minimal attention and resources are allocated toward enforcement of youth access laws. Local police are seen as having many other things to deal with, making tobacco a low priority.

There is also a need for sustainable funding. Organizations need help in making tobacco control programs an integral part of their long-term efforts and in better accommodating funding variability.

## What cessation issues exist for the African American community?

Greater access to culturally competent cessation services is needed. There is a need to better identify and promote existing cessation services as well as to expand the general availability of such services to the population.

Representatives of the African American community (focus group participants and key informants) cited these cessation issues:

- Faith-based cessation services might be very effective.
- African American women need cessation services that are tailored to their specific needs and issues; such services should be social in nature, fun, affordable, and accessible.
- Cessation services beyond those from the California Smokers' Helpline are needed

to meet the needs of African

American smokers. For

some, trying to work

through this issue on

the telephone is just too impersonal:

"You can't establish trust with someone you can't see."<sup>2</sup>

**There are no support groups for African American women trying to quit. I know a woman who has been trying to quit for three years and has been through many programs. They haven't worked for her. She needs a different approach.**

Beverly Jones-Wright, San Bernardino County Dept. of Public Health

## What areas are in need of further study?

Several interviewees and focus group participants cited the need for more surveys and input from the community in order to get more accurate data on tobacco use and to better define appropriate interventions and priorities.

<sup>2</sup> CDHS/TCS notes that the percentage of callers seeking assistance from the California Smokers' Helpline who were African American was 11.8 percent in 2002 and 12.5 percent in 2003, which is greater than their 6.9 percent representation among smokers in California, according to the 2002 California Tobacco Survey.

# Tobacco Control in the African American Community: Points to Remember

## Do's

- Be respectful.
  - Listen to input prior to action.
  - Ensure that input is valued.
  - Produce solutions that come from within the community.
  - Exercise flexibility and support for community-driven interventions.
  - Reach the African American audience where they gather.
  - Realize that language and literacy can be barriers. Use terms that are understandable and relevant. Recognize that the heart of the tobacco problem is addiction. People will not respond just to facts, because the addictive nature of tobacco products overwhelms the facts.
  - Provide individual attention.
  - Be visible in the community:  
"If they don't see you, they don't know you, and if they don't know you, they don't trust you."
  - Make a commitment to the community. Be there for the long-term, not just for one-time tobacco control projects. To nurture relationships, the tobacco control agency or coalition may have to participate in activities that have seemingly nothing to do with tobacco.
- Hire African American staff and make sure the program mirrors the values of the African American community.
  - Let the community take charge of the program.
  - Work within the community; they may not be experts in tobacco control, but they do know the community.
  - Be honest about the program's objectives.
  - Communicate with other tobacco control projects that serve similar communities.
  - Seek technical assistance from the African American Tobacco Education Partnership.

## Don'ts

- Don't act "like you know it all."  
"Don't be condescending.
- Don't interrupt someone when they are talking or having a conversation with someone else.
- Don't assume that because you know the language, you are the best person to deliver the message.
- Don't ignore racism and oppression. Recognize that these are very real issues the African American community faces every day.
- Don't try to be someone you're not.
- Trust and integrity are critical — don't say one thing and do another.
- Don't be patronizing by speaking in hip-hop or colloquial terms.
- Don't assume African Americans are defensive, antagonistic, or confrontational.

## Resources – Section 2

California Black Health Network/African American Tobacco Education Partnership  
[http://www.cbhn.org/AATEN\\_1.html](http://www.cbhn.org/AATEN_1.html)

National African American Tobacco Education Network, <http://www.naaten.org/>

National African American Tobacco Prevention Network, <http://www.naatpn.org/home/index.html>

National Association of African Americans for Positive Imagery, <http://www.naaapi.org/>

The Praxis Project, <http://www.thepraxisproject.org>

## References – Section 2

Brown, R., Y. Meng, S. Babey, and E. Malcolm. 2002. Asthma in California in 2001: High Rates Affect Most Population Groups. Los Angeles, California: California Health Interview Survey Policy Brief, UCLA Center for Health Policy Research.

Calif. Dept. of Finance.  
See State of California Department of Finance, Demographics Research Unit.

California Department of Health Services, Center for Health Statistics, Office of Health Information and Research. 2001. Healthy California 2010: Progress in Achieving the Healthy People Objectives, 2000-2004. Focus Area 3: Cancer. Objective 3-2: Lung Cancer. Available at <http://www.dhs.ca.gov/chs/OHIR/hp2010/hc2010progressfiles/objective0302.pdf>.

California Department of Health Services, Tobacco Control Section. California Student Tobacco Survey, 2001.

California Department of Health Services, Tobacco Control Section.  
California Tobacco Survey, 1990-1999.

California Department of Health Services, Tobacco Control Section.  
California Tobacco Survey, 1990-2002.

California Department of Health Services, Tobacco Control Section. California Tobacco Survey, 2002.

CHDS/CHS/OHIR. See California Department of Health Services, Center for Health Statistics, Office of Health Information and Research.

Siegel, M., MD, MPH. 2000. Tobacco Industry Sponsorship in the United States, 1995-1999. A publication of the Boston University School of Public Health. Available at <http://dcc2.bumc.bu.edu/tobacco/>

State of California Department of Finance, Demographics Research Unit. Population by Race/Ethnicity, Incorporated Cities by County, Census 2000. Available at [http://www.dof.ca.gov/HTML/DEMOGRAP/CSDC/CSDC\\_Products.htm](http://www.dof.ca.gov/HTML/DEMOGRAP/CSDC/CSDC_Products.htm)

Stockman, J., J. Von Behren, N. Shaikh, and R. Kreutzer. 2003. California Asthma Facts Volume 1, Issue 2. A publication of the Environmental Health Investigations Branch, California Department of Health Services. Available at <http://www.ehib.org/cma/papers/CaliforniaAsthmaFacts1203.pdf>

TIME Project. 2004. Tobacco Corporate Donations in California 2002-2004. Tobacco Industry Monitoring Evaluation – TIME Project, University of Southern California. Available on the password protected Web site [http://www.tcspartners.org/Main/WebSite/PS\\$corpdonations.pdf](http://www.tcspartners.org/Main/WebSite/PS$corpdonations.pdf)

Tobacco Technical Assistance Consortium (TTAC), ttac exchange (online publication), September 30, 2003, available at <http://www.ttac.org/enews/mailler09-30-03full.html>

USDHHS/NIH. See U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung and Blood Institute.

U.S. Bureau of the Census. Profile of General Demographic Characteristics for California: 2000. Available at <http://www.census.gov/prod/2002pubs/c2kprof00-ca.pdf>.

U.S. Bureau of the Census. The Black Population in the United States: March 2002. Available at <http://www.census.gov/prod/2003pubs/p20-541.pdf>.

U.S. Surgeon General. 1998. Tobacco Use Among U.S. Racial/Ethnic Minority Groups-African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung and Blood Institute. 2004. Morbidity & Mortality: 2004 Chart Book on Cardiovascular, Lung and Blood Diseases. Available at [http://www.nhlbi.nih.gov/resources/docs/04\\_chtbk.pdf](http://www.nhlbi.nih.gov/resources/docs/04_chtbk.pdf)

## Recommended indicators and assets for the African American community

### Highly Recommended Indicators: African American Community

1.1.1	Number and type of in-store tobacco advertising and promotions -or- Proportion of businesses with voluntary policies that regulate the extent and type of in-store tobacco ads and promotions
1.1.3	Number and type of tobacco advertisements in print media such as magazines and newspapers -or- Proportion of print media organizations (e.g., magazines and newspapers) with a voluntary policy that regulates tobacco advertising
2.2.1	Proportion of homes with a smoker in the household who report smoking -or- Proportion of families with a policy that does not permit smoking in the home
2.2.20	Proportion of faith community organizations (e.g., churches, synagogues, mosques, and temples) with a policy that regulates smoking on their grounds and at events
4.1.1	Number of culturally and linguistically appropriate behavior modification-based tobacco cessation services that are available and well utilized in the community

### Recommended Indicators: African American Community

1.1.2	<p>Number and type of tobacco advertising and promotions outside of stores</p> <p>-or-</p> <p>Proportion of businesses with a voluntary policy that regulates the extent and type of tobacco advertising and promotions outside of stores</p>
1.1.6	<p>Number and type of tobacco company sponsorship at public and private events including county fairs, rodeo, motor sports, other sporting events, parades, concerts, museums, dances, festivals, business, etc.</p> <p>-or-</p> <p>Proportion of entertainment and sporting venues with a voluntary policy that regulates tobacco company sponsorship including county fairs, rodeo, motor sports, other sporting events, parades, concerts, museums, dances, festivals, business, etc.</p> <p>-or-</p> <p>Proportion of communities with a policy that regulates tobacco company sponsorship at entertainment and sporting venues such as fairgrounds, concerts, museums, and events such as dance, business, festivals, etc.</p>
1.1.7	<p>Number and type of tobacco company sponsorship and advertising at bars and clubs</p> <p>-or-</p> <p>Proportion of bars and clubs with a voluntary policy prohibiting tobacco-company sponsorship and advertising</p>
1.1.11	<p>Number and type of tobacco use, tobacco advertising, and secondhand smoke depiction by the entertainment industry (e.g., movies, music videos, TV, music, etc.)</p> <p>-or-</p> <p>The extent that elected officials, parent organizations, health groups, and others adopt resolutions and voluntary policies that promote a socially responsible depiction of tobacco use, tobacco advertising, and secondhand smoke by the entertainment industry (e.g., movies, music videos, TV, music, etc.)</p>
3.3.1	Proportion of minors reporting they have received tobacco products from a social source

### Highly Relevant Assets: African American Community

2.5	Amount of community activism among adults to support tobacco control efforts
3.2	<del>Extent to which the LLA and other TCS-funded projects in the health jurisdiction include specific objectives in their workplans/scopes of work to address cultural or ethnic/minority communities or populations in relation to the demographics of the community<sup>3</sup></del>
3.3	Extent that the coalition or advisory committee by-laws and member agency mission statements promote cultural diversity and competency
3.6	Extent to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to the demographics of the community

<sup>3</sup> In 2004, Asset 3.2 was selected as a "highly relevant" asset for groups working with African American communities to assess. In 2006, assets were reviewed and, as a result, updated and revised. In this process, Asset 3.2 was retired and replaced with Asset 3.6 to help ensure that a diverse group of agencies are funded to address tobacco use.





# Section 3: Tobacco Control Issues in the American Indian and Alaska Native Community

## Key Points:

- California's American Indian and Alaska Native community has the highest adult smoking prevalence rate of any ethnic group, nearly double that of the state's adult population as a whole.
- The American Indian and Alaska Native population shows high rates of death and disease from tobacco.
- Respect for elders and protection of children are important cultural values to the American Indian and Alaska Native community.
- American Indians and Alaska Natives resist being told what to do from outsiders; they succeed best when they reach their own solutions.
- Tobacco control advocates must be sensitive to the distinction between ceremonial uses of native tobacco and abuse of commercial tobacco.
- The tobacco industry buys the support of the American Indian and Alaska Native population by sponsoring cultural, educational, and entertainment events and programs.
- Mainstream organizations must nurture relationships with tribal elders and community gatekeepers.
- American Indians and Alaska Natives perceive a need for greater access to culturally competent tobacco cessation services.

California's American Indian and Alaska Native community has the highest adult smoking prevalence rate of any ethnic group, nearly double that of the state's adult population as a whole.

Possible contributing factors include aggressive marketing by the tobacco industry, sovereignty issues that preclude the application of state tobacco control laws and regulations, and a cultural acceptance of tobacco use rooted in traditional and ceremonial uses.

The information in this chapter was collected from focus group interviews conducted in 2002, key informant interviews conducted in 2003, statistical reports available as of mid-2006, and literature searches conducted in 2004, 2005, and

2006. All of the quotes in the section are excerpts from the 2003 key informant interviews.

Much of the discussion that follows reflects the diverse opinions and perceptions of focus group participants and key informants, and should not be assumed to reflect in its entirety the views of CDHS/TCS.

**Many of the current health disparities are rooted, in part, in past segregationist practices resulting in inferior housing, education, and physical environments, as well as fewer economic opportunities for Native American communities and other communities of color**

(U.S. Commission on Civil Rights 2004).

## What is the smoking prevalence rate in California's American Indian and Alaska Native community?

In 2002, California's American Indians and Alaska Natives had a smoking prevalence rate of 30.1 percent (31.0 percent for American Indian and Alaska Native men and 29.1 percent for American Indian and Alaska Native women). American Indian and Alaska Native women had the highest smoking rate among all women in the state (California Tobacco Survey 2002).

The problem is not restricted to adults: U.S. data from 1999-2001 show American Indian and Alaska Native youth (ages 12-17) had the highest smoking prevalence rate when compared to other major racial/ethnic groups, at 27.9 percent (USDHHS/CDC 2004).

In addition, 14 percent of American Indian and Alaska Native men and 2 percent of American Indian and Alaska Native women use smokeless tobacco, over twice the rates of men and women in the general population (Hodge et al. 1999).

## Who are California's American Indians and Alaska Natives?

In 2000, California's 387,000 American Indians and Alaska Natives constituted approximately 1 percent of the state's population (Calif. Dept. of Finance, citing U.S. Census 2000).

There are 107 federally-recognized Indian tribes and 95 federal Indian reservations in the state of California, with about 40 Indian groups seeking to gain federal recognition. Prior to the arrival of the Europeans, the native peoples of California lived in all areas of the state. California Indians speak dozens of languages and dialects from seven major language families ([www.infodome.sdsu.edu](http://www.infodome.sdsu.edu)).

The majority of California's American Indian and Alaska Native residents live in urban areas. Los Angeles County is home to the greatest number of American Indians and Alaska Natives of any California county (with over 25,000), whereas Alpine County has the highest percentage of American Indians and Alaska Natives at 15 percent (188 American Indians out of a total county population of 1,208) (U.S. Census 2000).

In addition to the diversity in tribal affiliation, California's American Indian and Alaska Native community is diverse in many other ways, including economic status, educational attainment and literacy, religion (many are evangelical Christians), and age.

## In terms of tobacco control issues, what do the diverse groups in the American Indian and Alaska Native community have in common?

American Indians and Alaska Natives from diverse tribal backgrounds tend to share these traits:

- Respect is a very important value in the American Indian and Alaska Native community.
- They are family-oriented and care deeply about their children.
- Adults are very concerned about tobacco's effects on children's health.
- American Indians and Alaska Natives find it impolite to impose their wishes on others, such as asking friends not to smoke.
- American Indian and Alaska Native youth are well received as messengers and educators in the community.
- Smokers in the American Indian and Alaska Native population are fairly well aware of the health effects of tobacco, but find it very difficult to move from awareness to action.
- American Indians and Alaska Natives resist being told what to do by outsiders; they succeed best when they solve their own problems.

## What should tobacco control advocates know about the ceremonial use of tobacco?

The distinction between ceremonial use of tobacco and “commercial” use is crucial to understand, and the issue is fraught with more complexity than might be imagined at first glance.

Tobacco control advocates need to understand that some tribes have a tradition of using tobacco in ceremonial ways and for gift giving, and some do not. In addition, a phenomenon called “Pan-Indianism” is occurring, in which tribes sometimes adopt the traditions of other tribes, and this is leading to the ceremonial use of tobacco in tribes that formerly did not have this custom. Regardless of whether the ceremonial use of tobacco is ancient or modern, tobacco control advocates (especially non-Indian ones) are urged to honor its authenticity and steer away from condemnation.

In tribes that do use tobacco in sacred and ceremonial traditions, it is often used in spiritual cleansing rituals that do not require inhalation, and it is used for healing purposes. Tobacco is also given as a gift to elders, healers, and honored individuals at powwows, funerals, and other gatherings.

On the other hand, some American Indian and Alaska Native tobacco control advocates question the ceremonial validity of using commercial tobacco in place of traditionally grown tobacco, and they are particularly concerned that adults ignore the addictive nature of tobacco when giving it as a gift to children.

In terms of health and economic impacts to the American Indian and Alaska Native community, the focus needs to be placed on the habitual use of commercial tobacco

**Not all tribes use tobacco in a sacred way. For example, in Washoe tribal culture, cedar and sage are used for ceremony. Roots and mint are used for medicinal purposes.**

Adelina Osorio, Alpine County Health Department

rather than on the ceremonial use of natural or traditional tobacco. Therefore, in order to honor the ceremonial place of tobacco in American Indian and Alaska Native culture, anti-tobacco messages must be modified. For example, some tobacco control agencies working with American Indian and Alaska Native populations use the term “World No Tobacco Abuse Day” as opposed to “World No Tobacco Day.”

## In what ways have mainstream tobacco control efforts failed to address the needs of American Indians and Alaska Natives?

According to American Indian and Alaska Native community members, mainstream tobacco control advocates tend to take a hard-line approach to tobacco use, striving for a tobacco-free community, but in some American Indian and Alaska Native communities, tobacco plays an important role in ceremonies and traditions. Mainstream advocates’ failure to appreciate this cultural reality has contributed to a lack of communication and a feeling of mistrust on the part of American Indians and Alaska Natives.

Cultural competency issues also extend to the area of secondhand smoke. As sovereign nations that make their own laws, American Indian and Alaska Native tribes are not subject to state or federal tobacco control laws, such as those governing smoking in the workplace. As a result, exposure to secondhand smoke is high among this population. In the absence of legislated controls, the need for education is that much greater.

Furthermore, the mainstream tobacco control movement needs to help the American Indian and

Alaska Native community develop effective counter-marketing strategies to address tobacco advertising aimed at the American Indian and Alaska Native population.<sup>4</sup>

Finally, focus group participants noted a lack of funding for Indian-centered tobacco control activities and a shortage of people to do the work.

## How does the tobacco industry target the American Indian and Alaska Native community?

The tobacco industry commonly uses cultural symbols and designs to target American Indians and Alaska Natives, as well as to leverage and manipulate native culture to sell tobacco to non-Indian consumers. For example, American Spirit cigarettes were promoted as “natural” cigarettes, and the package featured an American Indian smoking a pipe.

To build its image and credibility in the community, the tobacco industry targets American Indians and Alaska Natives by funding cultural events such as powwows and rodeos (USDHHS 1998).

A study done by Michael Siegel at the Boston University School of Public Health that explored tobacco industry sponsorship in the years 1995 to 1999 identified these six tobacco industry sponsorships targeted at American Indians (Siegel 2000):

- The American Indian College Fund
- Dull Knife Memorial College in Montana, supporting courses to enhance teaching skills of teachers of the Cheyenne language
- Philip Morris/First Nations Development Fund for the Alleviation of Hunger

- Joslyn Art Museum in Omaha, NE, underwriting an exhibition of Plains Indians drawings
- Red Earth Native American Cultural Festival in Oklahoma City
- Teacher development programs at tribal colleges in North Dakota

## How can local tobacco control programs identify and reach out to American Indian and Alaska Native gatekeepers and collaborative partners?

American Indian and Alaska Native tobacco control advocates and community representatives suggested approaching these groups and individuals:

- State and national American Indian and Alaska Native tobacco control projects such as the American Indian Tobacco Education Partnership
- United Indian Health Services and other Indian health service clinics
- American Indian Education Centers
- American Lung Association (which has collaborated with American Indian communities in the past)

**Tobacco control programs can utilize health educators to get information to tribal leaders to create change. Go to the decision-makers first.**

Sachelle Jaime, Indian Health Council

It is very important to understand that American Indian and Alaska Native communities may not readily trust outsiders.

Agencies and coalitions from outside the community need to have a link, someone to serve as a liaison. Providing incentives to community leaders may be helpful in getting their cooperation.

It is also important to know that tribal decisions are usually made by elected council members. Outsiders need a connection to get on the agenda; in other words, the right gatekeeper must open the door.

<sup>4</sup> CDHS/TCS notes that American Indian and Native Alaskan populations are generally not served by specific media markets, as are African American, Spanish-speaking, and Asian-speaking populations, which increases the complexity of designing targeted advertising campaign strategies

## How can tobacco control materials and activities be made more culturally competent for the American Indian and Alaska Native community?

American Indian and Alaska Native tobacco control advocates and community representatives suggested these strategies:

- Link tobacco use to other health topics, such as sexually transmitted diseases, teen pregnancy, cancer, obesity, and diabetes.
- Train youth to share anti-tobacco messages with parents and other adults.
- Maintain a tobacco control presence at powwows, county fairs, and wellness centers.
- Be positive; stay away from negative or hard-edged messages.
- Encourage and empower people to make a change, but avoid telling them they must change.
- Emphasize the family and the community rather than the individual.
- Use American Indian and Alaska Native people to communicate the message.
- Videos, PowerPoint slides, and informal presentations at community meetings may be more effective than written materials.

## What specific kinds of messages might resonate with the American Indian and Alaska Native community?

Representatives of the American Indian and Alaska Native community cited two subject areas from which to draw powerful tobacco control messages: health and secondhand smoke exposure.

### Health

The health consequences of tobacco abuse in the American Indian and Alaska Native community are serious and compelling. Among them are the following:

- Prevalence of heart disease and the percentages of premature deaths are higher among Native Americans than among any other racial or ethnic group in the United States (Casper et al. 2005).
- In the United States in 1998, American Indians and Alaska Natives had higher smoking rates during pregnancy (20.2 percent) than any other ethnic group. This rate is 25 percent higher than non-Hispanic Whites who had the next highest rate at 16.2 percent (USDHHS 2001).

**Youth can  
carry the message;  
then people will stop and  
pay attention to the issue.**

Kathleen Jack, Four Winds of Indian Education

Community representatives suggested making links between tobacco use and other health issues prevalent in the American Indian and Alaska Native community, and to focus on the health of the family as opposed to focusing on the individual.

### Secondhand Smoke

Exposure to secondhand smoke among the American Indian and Alaska Native population is high both at home and in the workplace. There are efforts currently underway in California to work with Indian casinos to reduce exposure to secondhand smoke for both patrons and employees of casinos.

## What barriers and competing issues make it difficult to elevate the importance of tobacco control within the American Indian and Alaska Native community?

American Indian and Alaska Native communities face many difficult issues. Among them are the following:

- Unemployment and economic hardship

- Health issues such as diabetes
- Alcohol and drug addiction
- Depression
- Political and social strife

## What cessation issues exist in the American Indian and Alaska Native community?

Community representatives said that cessation has not been terribly successful in the American Indian and Alaska Native community. People inquire about services, but do not return for classes, or they get discouraged at the time commitment it takes. Group settings are difficult; the one-on-one approach seems to work best.

According to key informants and focus group participants, the California Smokers' Helpline is not perceived in the American Indian and Alaska Native community as being very successful. Community representatives said that American Indians and Alaska Natives often do not feel comfortable talking with someone they cannot see.<sup>5</sup>

## What areas are in need of further study?

Many American Indian and Alaska Native tobacco control advocates cite the need for tribal-specific data and the difficulty of obtaining it. In trying to assess a particular tribe or community, surveys must be short and confidential. Tribes are reluctant to share information about their problems to outside agencies; they own the data and they must determine what to do with it.

## Tobacco Control in the American Indian and Alaska Native Community: Points to Remember

### Do's

- Show respect.
- Be patient: It takes time for people to understand who you are and what you propose to do.
- Be aware of tribal differences (including the traditional use of tobacco).
- Identify the community's leaders and governing structure.
- Recognize the value of youth advocacy and elder/youth partnerships.
- Focus on the family and the community, rather than the individual.
- Be mindful of the tribal calendar, e.g., ceremonies and times when people don't travel.
- Assist with logistics of meetings and activities, such as bringing food and reimbursing for expenses.

### Don'ts

- Don't assume that the decision-making process mirrors standard government or organizational practices. Tribal decisions are generally overseen by elders who have unique processes for how and when decisions are made.
- Don't assume that American Indians and Alaska Natives are fully aware of how they are targeted by the tobacco industry.
- Don't be pushy or bossy.
- Don't assume that all tribes use tobacco in a sacred way. Some tribes use other plants such as sage, cedar, and cornmeal instead of tobacco.

<sup>5</sup> CDHS/TCS notes that in 2002, 2.3 percent of the callers to the California Smokers' Helpline were American Indians and Alaska Natives

## Resources – Section 3

California Rural Indian Health Board, Inc.  
<http://www.crihb.org/home.htm>

## References – Section 3

Casper, M., C. Denny, J. Coolidge, G. Williams, Jr., A. Crowell, J. Galloway, and N. Cobb. 2005. *Atlas of Heart Disease and Stroke Among American Indians and Alaska Natives*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and Indian Health Service. Available at [http://www.cdc.gov/dhdsp/library/aian\\_atlas/pdfs/aian\\_atlas.pdf](http://www.cdc.gov/dhdsp/library/aian_atlas/pdfs/aian_atlas.pdf)

CDC. See U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Center for Health Policy Research, University of California, Los Angeles, in collaboration with the California Department of Health Services and the Public Health Institute. 2002. *California Health Interview Survey, 2001*.

Hodge, F., L. Fredericks, and P. Kipnis. 1999. "It's your Life--It's our Future" Stop Smoking Project. In C. Glover and F. Hodge, eds., *Native Outreach: A Report to American Indian, Alaska Native, and Native Hawaiian Communities*, NIH publication 99-4341, pp. 67-74. Washington, DC: National Institutes of Health, National Cancer Institute.

San Diego State University Library and Information Access at <http://infodome.sdsu.edu/research/guides/calindians/calind.shtml>

Siegel, M., MD, MPH. 2000. *Tobacco Industry Sponsorship in the United States, 1995-1999*. A publication of the Boston University School of Public Health. Available at <http://dcc2.bumc.bu.edu/tobacco/>

United States Bureau of the Census. *Profile of General Demographic Characteristics for California: 2000*. Available at <http://www.census.gov/prod/2002pubs/c2kprof00-ca.pdf>.

United States Commission on Civil Rights. 2004. *Broken Promises: Evaluating the Native American Health System*. Available at <http://www.usccr.gov/pubs/nahealth/nabroken.pdf>

USDHHS. See U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services. 1998. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups-African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2004. *Prevalence of cigarette use among 14 racial/ethnic populations - United States, 1999-2001*. *Morbidity and Mortality Weekly Report (MMWR)*;53(3):49-52.

U.S. Department of Health and Human Services. 2001. *Women and Smoking: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Available at [http://www.cdc.gov/tobacco/sgr/sgr\\_forwomen/sgr\\_women\\_chapters.htm](http://www.cdc.gov/tobacco/sgr/sgr_forwomen/sgr_women_chapters.htm)



## Recommended indicators and assets for the American Indian and Alaska Native community

### Highly Recommended Indicators: American Indian and Alaska Native Community

1.3.1	Proportion of schools that provide instruction on tobacco-use prevention that meets CDC guidelines (e.g., intensive tobacco use prevention instruction in junior high/middle school years with reinforcement in high school using a curricula that provides instruction on the negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills)
1.3.2	Proportion of schools or school districts that provide tobacco use prevention specific instruction for teachers
2.1.2	<p>Number of compliance checks conducted by tribal enforcement agencies for violations with American Indian tribal indoor smoke-free worksite policies, <b>excluding gaming/leisure complexes</b> policies</p> <p>-or-</p> <p>Number of warnings, citations, and fines issued by tribal enforcement agencies for violations of indoor smoke-free worksite policies, <b>excluding gaming/leisure complexes</b> policies</p> <p>-or-</p> <p>Proportion of worksites in compliance with indoor smoke-free American Indian worksite policies, <b>excluding gaming/leisure complexes</b> policies</p>
4.1.1	Number of culturally and linguistically appropriate behavior modification-based tobacco cessation services that are available and well utilized in the community
4.2.2	Number of managed care organizations in the community that have implemented the U.S. Public Health Service clinical practice guidelines <i>Treating Tobacco Use and Dependence</i>

### Recommended Indicators: American Indian and Alaska Native Community

1.1.1	<p>Number and type of in-store tobacco advertising and promotions</p> <p>-or-</p> <p>Proportion of businesses with voluntary policies that regulate the extent and type of in-store tobacco ads and promotions</p>
1.1.3	<p>Number and type of tobacco advertisements in print media such as magazines and newspapers</p> <p>-or-</p> <p>Proportion of print media organizations (e.g., magazines and newspapers) with a voluntary policy that regulates tobacco advertising</p>
1.1.10	<p>Amount of tobacco industry contributions to support political campaigns of elected officials or political caucuses</p> <p>-or-</p> <p>Proportion of elected officials or political caucuses that have signed a pledge not to accept tobacco company contributions</p>
1.1.13	Amount and quality of news media stories about tobacco industry practices and political lobbying
1.2.4	Proportion of communities with policies that increase the price of tobacco products and generate revenue with a portion of the revenue earmarked for tobacco control efforts (e.g., taxes, mitigation fees)



### Highly Relevant Assets: American Indian and Alaska Native Community

1.3	Amount of local Prop 10 funds that are appropriated for cessation and secondhand smoke education targeting pregnant women and families with young children
3.4	Extent that educational and media materials used by the agency reflect the culture, ethnicity, sexual orientation, and languages of the communities served, relative to the demographics of the community
3.5	<del>Extent that bilingual staff, subcontractors and consultants are part of the LLA and TCS-funded projects in proportion to the demographics of the local health jurisdiction<sup>6</sup></del>
3.7	Extent to which a tobacco control program implements organizational policies and practices that promote and institutionalize the provision of culturally competent and linguistically appropriate services for diverse populations, including organizational values that articulate commitment to cultural competency, participatory collaborative planning, provision of community capacity building, translation policies, staff diversity, and formative research/surveillance within diverse communities

<sup>6</sup> In 2004, Asset 3.5 was selected as a “highly relevant” asset for groups working with American Indian and Alaskan Native communities to assess. In 2006, assets were reviewed and, as a result, updated and revised. In this process, Asset 3.5 was retired and replaced with Asset 3.7 to encourage all organizations to address diversity issues through a broad range of organizational practices and policies beyond having bilingual staff.



# Section 4: Tobacco Control Issues in the Asian and Pacific Islander Community

## Key Points:

- Taken as a whole, the Asian and Pacific Islander (API) community shows a relatively low rate of smoking. However, when the data are disaggregated, it becomes clear that certain subpopulations of this community have exceedingly high rates of tobacco use.
- One must be extremely cautious when generalizing about a community that encompasses such an enormous degree of diversity.
- Within the API community, there are significant gender differences and generational differences in attitudes toward tobacco use.
- Community representatives say that better collaboration is needed between language-competent community-based organizations and mainstream tobacco control organizations.
- The API community should focus on tobacco as a transnational issue.
- The tobacco industry is making a concerted effort to target the API community.
- Mainstream organizations need to build relationships with API gatekeepers and community leaders.
- There is a great need for language-competent anti-tobacco materials and programming.
- Cessation services for the API community might be more successful if they involved the medical community, which has a great deal of credibility among this population.

Smoking harms the health and economic well-being of people in California's Asian and Pacific Islander (API) community. Reasons for tobacco use in this community include immigration from countries of origin in which smoking is an acceptable social norm, targeting by the tobacco industry, a shortage of culturally competent cessation services, and language barriers that impede the anti-tobacco message.

The information in this chapter was collected from focus group interviews conducted in 2002, key informant interviews conducted in 2003, statistical reports available as of mid-2006, and literature searches conducted in 2004, 2005, and 2006. All of the quotes in the chapter are excerpts from the 2003 key informant interviews. Much of the discussion

that follows reflects the diverse opinions and perceptions of focus group participants and key informants, and should not be assumed to reflect in its entirety the views of CDHS/TCS.

## What is the smoking prevalence rate in California's Asian and Pacific Islander community?

In 2002, the most recent year for which data are available, 12.1 percent of the API population consisted of current smokers, which is relatively low compared to other ethnic groups. However, when

disaggregated in terms of gender and country of origin, the data show high rates of prevalence in specific segments of the API community. For example, the overall rate of smoking among API males was 17.7 percent, whereas the rate among API females was only 6.8 percent (lowest among all demographic groups surveyed) (California Tobacco Survey 2002). Recent research has shown that Cambodian American men have rates of smoking as high as 71 percent in some communities, and prevalence rates range from 48 percent to 72 percent for Laotian American men (Lew 2004).

In 2004, 8.4 percent of California's API high school students were current smokers (California Student Tobacco Survey 2004). The years immediately following high school are crucial in terms of tobacco control—the majority of API smokers reported initiating smoking as young adults between the ages of 18 and 21 (Trinidad et al 2004).

## Who is California's Asian and Pacific Islander community?

The API community is the fastest growing racial/ethnic group nationwide. The term Asian and Pacific Islander refers to a group of people having origins in any of the original peoples of Asia, including East Asia, Southeast Asia, West Asia, and South Asia; Pacific Islanders include people from Polynesian, Micronesian, and Melanesian ancestries. Taken as a single demographic group, API represents approximately thirty Asian and twenty-five Pacific Island nationalities. Not surprisingly, given the vast geographical range of Asia and the Pacific Islands, API subgroups differ in language, religion, health status and concerns, customs and beliefs, and many other characteristics.

- The combined Asian population of approximately 3.7 million people comprises nearly 11 percent of California's population (US Census 2002).
- In 2000, there were nearly 117,000 Native Hawaiians and other Pacific Islanders in

California. More than half of the United States' Native Hawaiians and other Pacific Islanders reside in California (US Census 2001).

- Immigration has been a major factor in the growth of the API population, and the percent of foreign-born individuals varies by ethnicity: in 1990, over 60 percent of Japanese Americans were native born compared to 20 percent of Vietnamese Americans (Ro 2002).
- The 2000 census found that in California, the major subgroups of the API population represented these nationalities or regional affiliations (US Census 2002):

Nationality	Percent of total California API Population of 3.7 million
Chinese	25.7 percent
Filipino	24.1 percent
Vietnamese	11.7 percent
Other Asian	10.5 percent
Korean	9.1 percent
Asian Indian	8.3 percent
Japanese	7.6 percent
Pacific Islander	3.1 percent

Country of origin or culture is only one of a great many characteristics that encompass the enormous diversity within the API community. Within particular communities and among particular individuals, significant differences that may influence tobacco control issues include

- Length of time since immigration and degree of acculturation
- Language
- Cultural norms, e.g., signs of courtesy and respect, and social taboos
- Age
- Gender
- Socioeconomic status
- Social and political history of the group in the United States
- Educational attainment/literacy
- Religious affiliation

## In terms of tobacco control issues, what do the diverse groups in the Asian and Pacific Islander community have in common?

Despite the immense diversity within the API community, many commonalities exist:

- There is a long history of tobacco use among several of the API populations.
- Significant gender differences exist in smoking prevalence rates, and acculturation also plays a role. Women who speak English at home are significantly more likely to smoke cigarettes than those who speak their native languages at home (Tang 2002).
- Generational differences exist in tobacco use and perception. The older generation tends to be more accepting of tobacco use and less concerned with its physical effects.
- More recently immigrated Asian Americans tend to view tobacco in a less negative way and are less concerned with the hazards caused by tobacco use.
- Anti-tobacco work may be seen as an attack on a revered culture and way of life. Deviating from or attacking one's culture is not seen as acceptable behavior in the API community.
- Respect for elders is an important value.

## In what ways have mainstream tobacco control efforts failed to address the needs of the Asian and Pacific Islander community?

API focus group participants and key informants made the following comments about the current

state of tobacco control in their community:

- Mini-grants are useful sources of funding, but are too short-term and too small to be highly successful in achieving tobacco control outcomes. Additionally, the process of getting the mini-grants takes a great deal of work for a small amount of money.
- Language-competent community based organizations (CBOs) do not often work on tobacco control, and tobacco control organizations are usually not competent to work in the API community. Better collaboration is needed.
- CBOs need resources to build organizational and program capacity. In addition, investment needs to be made to ensure that there is a sustained tobacco control infrastructure.
- Visible, proactive, and consistent anti-tobacco education outreach is lacking in API communities.
- It is very difficult to find culturally competent cessation services.

## How does the tobacco industry target the Asian and Pacific Islander community?

**The individual must be bombarded from many different places — the more messages the better from outreach workers, health care providers, family members, and media.**

Tina Chinakarn, Frank D. Lanterman Regional Center, Los Angeles

Perhaps more than any other ethnic or racial group, the API community may want to focus on the tobacco industry as a transnational phenomenon. The tobacco industry has heavily infiltrated Asian media, and exposure to this media saturation strongly influences immigrant populations in the United States.

Newspapers, magazines, and DVDs produced for Asian consumers are full of tobacco advertising and depict tobacco use in a favorable light. For example, DVDs from Vietnam and Cambodia have tobacco ads in which cigarette packs bounce across the screen.

Tobacco industry documents reveal a three-pronged strategy to (1) develop strong relationships with API business owners, (2) tailor advertising specifically to young API adults, including young women, and (3) engage in “corporate goodwill” by promoting community events.

The tobacco industry has a hand in events and organizational sponsorship locally, nationally, and internationally. For example, in California and elsewhere, there is evidence that tobacco companies are trying to sponsor import car shows, auto races, and hip-hop concerts, thereby targeting young API adults.

A study done by Michael Siegel at the Boston University School of Public Health that explored tobacco industry sponsorship in the years 1995 to 1999 identified the following three tobacco industry sponsorships that targeted specific API communities (Siegel 2000):

- The Asian American Expo (El Monte, California, 1998)
- A black-tie dinner for the Congressional Asian Pacific American Caucus (1997)
- Publication of the Organization of Chinese Americans National Directory of Asian Pacific American Organizations (1995, 1997)

In 2002, Altria (Philip Morris) donated \$24,000 to a California project called Boat People SOS that served Vietnamese immigrants (TIME Project 2004).

## **How should local programs identify and reach out to Asian and Pacific Islander gatekeepers and collaborative partners?**

It can be difficult for outsiders to come into the API community and work successfully. There needs to be an initial investment in time to develop the community’s trust before a successful working relationship can be established. Community

gatekeepers are important as partners and help to give credibility and develop trust of those not a part of the community.

Tobacco control advocates from the API community suggested the following:

- Seek out existing community programs and services and build relationships with them so that tobacco control issues can be addressed by and with them.
- Realize that building effective relationships with existing community programs and organizations takes time and cannot be expected to happen overnight.
- Honor and follow the cultural protocols that exist within CBOs.
- Recognize that CBOs are driven by their funding streams; most of the time, their funds are already designated for other projects. Thus, there may be resistance to expanding their agendas further to include tobacco control.
- Doctors can play a key role in disseminating anti-tobacco information, especially if the language of the doctor matches that of the patient. In most API communities, doctors are held in great respect. Exceptions to this general rule exist, however. For example, in the Pacific Islander community, ministers and other religious leaders may have more influence than doctors.
- Do not be afraid to ask questions. Take the time to find out about the community before making assumptions.

Representatives of various API communities suggested these California organizations as potential partners:

- Asian Pacific Health Care Venture (Los Angeles)
- Korean Youth Community Association (Los Angeles)
- Vietnamese Voluntary Foundation (San Jose)
- Cambodian Association of America (Long Beach)
- American Heart Association of California
- Asian Health Services (Oakland)
- Vietnamese Community Health Promotion Project (San Francisco)

- Guam Communications Network (Long Beach)
- Union of Pan Asian Communities (San Diego)
- California Health Collaborative (Fresno)
- Asian & Pacific Islander American Health Forum (San Francisco)/AAPI Partnership Project

## How can tobacco control materials and activities be made more culturally competent for the Asian and Pacific Islander community?

Tobacco control advocates from the API community suggested these strategies:

- Try more “hard-hitting” messages in anti-tobacco advertising.
- Focus on tobacco’s impact on the whole family.
- Start with easy-to-grasp concepts before jumping into some of the more complex issues of tobacco control.
- Similarly, begin with short-term goals such as improving the community’s access to cessation services, rather than more long-term goals such as eliminating health care disparities.
- Develop materials in many more of the API languages and target different generations within the community.
- Facilitate more collaborative work between tobacco control organizations and language-capable CBOs that are working on other issues.
- Take advantage of community-wide events such as Asian New Year’s celebrations.
- Begin with a message of “no smoking in the home.”
- Focus on the prevention of sales to minors in API neighborhoods and API-owned stores.
- Use API newspapers as the medium of choice for most communities, followed by television and in-language radio.

As much as possible, tobacco control programming should be based on local data. Focus group

participants and key informants often disagreed with conclusions drawn from statewide data. For example, a statewide survey found that the more acculturated an API woman was, the more likely she was to smoke. However, one key informant commented recently arrived immigrant girls from Southeast Asia appear to smoke a lot.

For API youth, tobacco control materials and activities should do the following:

- Deglamorize tobacco use.
- Use hip-hop culture (i.e., the most up-to-date popular youth culture) in anti-tobacco advertising.
- De-emphasize the health message.
- Prevent the tobacco industry from infiltrating import car activities.
- Take advantage of the fact that API young people do not like anyone smoking in their cars.
  - Reveal tobacco industry tactics in local API neighborhoods and communities.
- Try a social justice message; teach youth about the global nature of the tobacco problem, and how the tobacco industry is exploiting workers in their home countries.
- Use teens and young adults to talk to younger children.

**Information is important, but process is very important. Involve the community in all aspects of development and planning.**

Rod Lew, Asian Pacific Partners for Empowerment and Leadership (APPEAL)

## What specific kinds of messages might resonate with the Asian and Pacific Islander community?

Representatives from the Asian and Pacific Islander community cited four subject areas from which to draw powerful tobacco control messages: health, secondhand smoke, economic impact, and social justice.

### Health

Among many segments of the API population, the hazards of tobacco use are not well known

and a great deal of education is needed. In other segments of the population, there is a general awareness that smoking is unhealthy, but not a clear understanding of its impact on specific health outcomes such as heart disease. Generally speaking, doctors and nurses have the most credibility as messengers of health-related messages.

In terms of tobacco related illnesses, in 2002, cancer was the leading cause of death among Asian Americans, with heart disease second (Anderson and Smith 2005). Tobacco smoke is also a known trigger of asthma attacks; 1 in 7 members of the API population have been diagnosed with asthma (Brown et al 2002).

### Secondhand Smoke

Given the strong emphasis on protecting children and families in the API cultures, framing the prevention of secondhand smoke as a child protection issue is very successful. According to the California Tobacco Survey (2002), 94.3 percent of API households with children or adolescents in the home had a total ban on smoking in the home.

### Economic Impact

API families and small business owners may be interested to learn about the financial burdens imposed by tobacco use. In addition to the direct cost of purchasing tobacco products for the individual smoker, employees who smoke cost businesses in terms of higher health care costs and reduced productivity.

### Social Justice

Communities that are politically active and well organized, such as the Korean and Chinese communities, as well as API college students, may be receptive to social justice issues such as the exploitation of workers and governmental corruption in their countries of origin.

## What barriers and competing issues make it difficult to elevate the importance of tobacco control within the Asian and Pacific Islander community?

Key informants noted that API communities face many difficult issues, including the following:

- Intergenerational conflicts between immigrants and their American-born children
- Acculturation difficulties
- Language barriers
- Unemployment and underemployment
- Lack of health insurance

There are also attitudinal challenges. Because the effects of tobacco are often not seen until later in life, people tend not to see the urgency of tobacco-related issues. Sentiments such as “we all have to die eventually” and “my grandparents smoked and they lived into their 90s” are common.

**Doctors do play a key role in people’s health in the API community, but they must take advice to a different level by including the family in health care issues.**

Tana Lepule, Union of Pan Asian Communities (UPAC)

There are a few API cultural groups that traditionally use tobacco as a gift at weddings and funerals. API tobacco control advocates suggested an educational campaign in which people are encouraged to offer alternative gift items on these occasions.

## What cessation issues exist in the Asian and Pacific Islander community?

The California Smokers’ Helpline provides services in Cantonese/Mandarin, Korean, and Vietnamese. Other API language groups are perceived by the community as being underserved. (CDHS/TCS notes that in 2002, 9.2 percent of the calls to the Helpline came from Asians in English and in Asian languages.)



Community representatives said that cessation services would be most successful if they involved the medical community, preferably API doctors and nurses. Medical professionals have a lot of credibility in the API community.

There is a perception among tobacco control advocates in the API community that self-help support groups have not proven very effective.

## What areas are in need of further study?

Key informants suggested that more research is needed in the following areas:

- Denormalizing tobacco use in populations of new API
- Defining the economic impact of tobacco use in terms of the individual smoker, the family, and the community
- Effective cessation strategies
- Countering tobacco industry targeting of the API community

## Tobacco Control in the Asian and Pacific Islander Community: Points to Remember

### Do's

- Build trust.
- Show respect.
- Recognize that cultural norms are strong; deviation is discouraged.
- Acknowledge that youth are expected to be obedient to parents and elders. Asking youth to challenge the beliefs and habits of the older generation might not be appropriate.
- Be aware of the emphasis

on protecting children and the family.

- Learn about the various national and cultural groups within the larger API population.
- Build relationships within API communities.
- Use gatekeepers and liaisons to work with API communities.
- Get community input before starting a project.
- Information is important but the process is very important.
- Use messengers from within API communities.
- Be aware that a few API sub-groups use tobacco in ceremonial or gift-giving fashion.
- Recognize that tobacco may serve as a link between immigrants and their homeland's culture.
- Be aware that most immigrants' worldviews consists of both the "mainstream" California culture and the culture of their homeland.
- When trying to bring disparate subgroups together, understand that social and political history (e.g., events during World War II, the Korean conflict, and the war in Southeast Asia) can influence present day interactions.
- When meeting with leaders of API communities, keep these tips in mind:
  - Take food that is offered to you; to decline is a sign of disrespect.
  - Always greet elders first.
  - Sit lower than the elders.
  - Always show respect.
  - Refrain from interrupting others when they are talking.

### Don'ts

- Don't forget: language, language, language. Use interpreters whenever necessary.
  - Don't assume individuals or organizations from the various API subgroups work well together or even like each other very much. Be prepared to work hard to bridge gaps and demonstrate where their common interests lie.

**The API community knows that smoking is not good for your health, and most have tried to stop. They need clear specific methods of how to do it and where to go for help.**

Stella Jun, Bay Area Community Resources  
RIDE Project

## Resources – Section 4

Asian and Pacific Islander Tobacco Education Network  
<http://www.apiahf.org/programs/apiten/index.htm>

## References – Section 4

Anderson, R., and B. Smith. 2005. Deaths: Leading causes for 2002. National Vital Statistics Reports Vol. 53, No. 17. Hyattsville, Maryland: U.S. Department of Health and Human Services, Centers for Disease Control, National Center for Health Statistics. Available at [http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53\\_17.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf)

Brown, R., Y. Meng, S. Babey, and E. Malcolm. 2002. Asthma in California in 2001: High Rates Affect Most Population Groups. Los Angeles: California Health Interview Survey Policy Brief, UCLA Center for Health Policy Research.

California Department of Health Services, Tobacco Control Section. California Student Tobacco Survey. 2001.

California Department of Health Services, Tobacco Control Section. California Tobacco Survey, 1990-2002.

California Department of Health Services, Tobacco Control Section. Jan. 14, 2003. Press Release 153306. Available at <http://www.dhs.ca.gov/tobacco/documents/PressRelease153306.pdf>. 2003.

Lew, R. 2004. Association of Asian Pacific Community Health Organizations. Tobacco Disparities, Asian Americans and Pacific Islanders, and the Need for Social Justice. Presented to the Interagency Committee on Smoking and Health, March 9, 2004, available at <http://www.aapcho.com/links/SGpresentation04.pdf>.

Ro, Marguerite. 2002. Overview of Asian and Pacific Islanders in the United States and California. Battle Creek, MI: W.K. Kellogg Foundation. Available at <http://www.communityvoices.org/Articles/Results-Publications.asp>.

Siegel, M., M. D., M. P. H. 2000. Tobacco Industry Sponsorship in the United States, 1995-1999. A publication of the Boston University School of Public Health. Available at <http://dcc2.bumc.bu.edu/tobacco/>

Tang, H. 2002. Tobacco use among Asian sub-populations in California. Poster presented at the American Public Health Association Annual Meeting, Philadelphia, PA: November 2002.

TIME Project. 2004. Tobacco Corporate Donations in California 2002-2004. Tobacco Industry Monitoring Evaluation – TIME Project, University of Southern California. Available on the password protected Web site [http://www.tcspartners.org/Main/WebSite/PS\\$corpdonations.pdf](http://www.tcspartners.org/Main/WebSite/PS$corpdonations.pdf)

Trinidad, D., E. Gilpin, L. Lee, and J. Pierce. 2004. Do the majority of Asian-American and African-American smokers start as adults? American Journal of Preventive Medicine: 26(2):156-158.

U.S. Bureau of the Census. 2002. The Asian Population: 2000. Available at <http://www.census.gov/prod/2002pubs/c2kbr01-16.pdf>

U.S. Bureau of the Census. 2001. The Native Hawaiian and Other Pacific Islander Population: 2000. Available at <http://www.census.gov/prod/2001pubs/c2kbr01-14.pdf>

U.S. Department of Health and Human Services (USDHHS). 1998. Tobacco Use Among U.S. Racial/Ethnic Minority Groups-African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

# Recommended indicators and assets for the Asian and Pacific Islander (API) community

## Highly Recommended Indicators: Asian and Pacific Islander Community

1.1.3	<p>Number and type of tobacco advertisements in print media such as magazines and newspapers</p> <p>-or-</p> <p>Proportion of print media organizations (e.g., magazines and newspapers) with a voluntary policy that regulates tobacco advertising</p>
1.1.6	<p>Number and type of tobacco company sponsorship at public and private events including county fairs, rodeo, motor sports, other sporting events, parades, concerts, museums, dances, festivals, business, etc.</p> <p>-or-</p> <p>Proportion of entertainment and sporting venues with a voluntary policy that regulates tobacco company sponsorship including county fairs, rodeo, motor sports, other sporting events, parades, concerts, museums, dances, festivals, business, etc.</p> <p>-or-</p> <p>Proportion of communities with a policy that regulates tobacco company sponsorship at entertainment and sporting venues such as fairgrounds, concerts, museums, and events such as dance, business, festivals, etc.</p>
1.1.7	<p>Number and type of tobacco company sponsorship and advertising at bars and clubs</p> <p>-or-</p> <p>Proportion of bars and clubs with a voluntary policy prohibiting tobacco-company sponsorship and advertising</p>
2.2.1	<p>Proportion of homes with a smoker in the household who report smoking</p> <p>-or-</p> <p>Proportion of families with a policy that does not permit smoking in the home</p>
4.1.1	<p>Number of culturally and linguistically appropriate behavior modification-based tobacco cessation services that are available and well utilized in the community</p>

### Recommended Indicators: Asian and Pacific Islander Community

1.1.1	<p>Number and type of in-store tobacco advertising and promotions</p> <p>-or-</p> <p>Proportion of businesses with voluntary policies that regulate the extent and type of in-store tobacco ads and promotions</p>
1.1.2	<p>Number and type of tobacco advertising and promotions outside of stores</p> <p>-or-</p> <p>Proportion of businesses with a voluntary policy that regulates the extent and type of tobacco advertising and promotions outside of stores</p>
1.1.10	<p>Amount of tobacco industry contributions to support political campaigns of elected officials or political caucuses</p> <p>-or-</p> <p>Proportion of elected officials or political caucuses that have signed a pledge not to accept tobacco company contributions</p>
2.1.1	<p>Number of compliance checks conducted by enforcement agencies for violations of indoor smoke-free worksite policies, <b>excluding bars and gaming</b> policies</p> <p>-or-</p> <p>Number of warnings, citations, and fines issued for violations of indoor smoke-free worksite policies, <b>excluding bars and gaming</b> policies</p> <p>-or-</p> <p>Proportion of worksites in compliance with indoor smoke-free worksite policies <b>excluding bars and gaming</b> policies</p>
2.2.20	<p>Proportion of faith community organizations (e.g., churches, synagogues, mosques, and temples) with a policy that regulates smoking on their grounds and at events</p>

### Highly Relevant Assets: Asian and Pacific Islander Community

2.1	Number of tobacco control advocacy trainings that are provided to youth and adults
2.4	Amount of community activism among youth to support tobacco control efforts
3.2	Extent to which the LLA and other TCS-funded projects in the health jurisdiction include specific objectives in their workplans/scopes of work to address cultural or ethnic/minority communities or populations in relation to the demographics of the community <sup>7</sup>
3.6	Extent to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to the demographics of the community

<sup>7</sup> In 2004, Asset 3.2 was selected as a "highly relevant" asset for groups working with African American communities to assess. In 2006, assets were reviewed and, as a result, updated and revised. In this process, Asset 3.2 was retired and replaced with Asset 3.6 to help ensure that a diverse group of agencies are funded to address tobacco use.

# Section 5: Tobacco Control Issues in the Hispanic/Latino Community

## Key Points:

- In 2002, the smoking prevalence rate among California's adult Hispanic/Latino population was 13.4 percent.
- Subpopulations of the Hispanic/Latino community show enormous diversity in smoking behavior and attitudes toward tobacco use.
- The tobacco industry is making a concerted effort to target the Hispanic/Latino community.
- Mainstream tobacco control organizations need to build relationships with Hispanic/Latino gatekeepers and community leaders.
- There is a need for improved Spanish-language anti-tobacco materials and programming.
- Hispanic/Latino tobacco cessation advocates perceive a need for greater access to culturally competent tobacco cessation services.

Smoking continues to have health and economic consequences for California's Hispanic/Latino community. Reasons for tobacco use in this community include cultural norms in which smoking is acceptable in some populations, population-specific targeting by the tobacco industry, and language barriers that impede the anti-tobacco message.

The information in this chapter was collected from focus group interviews conducted in 2002, key informant interviews conducted in 2003, statistical reports available as of mid-2006, and literature searches conducted in 2004, 2005, and 2006. All of the quotes in the chapter are excerpts from the 2003 key informant interviews. Much of the discussion that follows reflects the diverse opinions and perceptions of focus group participants and key informants, and should not be assumed to reflect in its entirety the views of CDHS/TCS.

## What is the smoking prevalence rate in California's Hispanic/Latino community?

In 2002, the smoking prevalence rate among California's adult Hispanic/Latino population was 13.4 percent, which equates to almost 1.5 million Hispanic smokers in the state. Within the Hispanic/Latino population, there is enormous diversity in smoking behavior. The rate of smoking among Hispanic/Latino males was 19.0 percent, whereas the rate among Hispanic/Latina females was only 7.4 percent (California Tobacco Survey 2002). Smoking prevalence rates also varied greatly by country of origin or heritage, with people from Puerto Rico showing the highest rates among the Hispanic/Latino subgroups (USDHHS 2004).

In 2004, 13.5 percent of California's Hispanic/Latino high school students were regular smokers (California Student Tobacco Survey 2004).

## Who is California's Hispanic/Latino community?

The United States Census defines Hispanic/Latino people as originating from Spanish speaking countries or regions, and notes that origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. Hispanics can be of any race. California's Hispanic/Latino residents, totaling almost 11 million people, account for more than 32 percent of the state's population (U.S. Census 2001).

Seventy-seven percent of California's Hispanics/Latinos are of Mexican ancestry and 5 percent identify themselves as being of Central American ancestry. Fewer than 2 percent of California's Hispanics/Latinos describe Puerto Rico, Cuba, or the Dominican Republic as their country of origin or heritage (U.S. Census 2002).

Among California's counties, Los Angeles County is home to the largest number of Hispanic/Latino residents (with 4.3 million), and Imperial County has the highest percentage of Hispanic/Latino residents (72.2 percent). Based on the 2000 Census, there are 20 counties in California where Hispanics/Latinos represent greater than 30 percent of the total population. It is projected that by 2010, Hispanics/Latinos will represent 42 percent of California's total population (U.S. Census 2002).

Country of origin is one of many characteristics that reflect the great diversity within the Hispanic/Latino community.

Within particular subpopulations, significant differences that may influence tobacco control issues include

- Nativity (native vs. foreign born)
- Length of time since immigration and degree of acculturation
- Primary language (Spanish/English)
- Spanish Dialect (regional dialects vary greatly)
- Age
- Gender
- Socioeconomic status
- History of the group in the United States
- Educational attainment/literacy
- Religious affiliation

## In terms of tobacco control issues, what do the diverse groups within the Hispanic/Latino community have in common?

Despite the diversity among the various Hispanic/Latino subgroups, some commonalities exist:

- Hispanic/Latina women who speak English at home are significantly more likely to smoke cigarettes than those who speak their native languages at home. This trend was not observed among Hispanic/Latino men (California Tobacco Survey 2002).
- Generational differences exist in tobacco use and perception among older versus younger Hispanic/Latino people.
- Hispanic/Latino families value respect for elders and parents.
- Hispanic adults strive to be positive role models for youth.

**Not all Latinos are Mexican. These are broad populations from all over Latin America and Europe. Language, food, and culture vary greatly. Immigrating populations have separate assimilation issues. These are humble people proud of being in the USA and of succeeding and having a better life.**

Nora Manzanilla, Office of the City Attorney, Los Angeles

## In what ways have mainstream tobacco control efforts failed to address the needs of the Hispanic/Latino community?

Focus group participants and key informants made the following comments about the current state of tobacco control in the Hispanic/Latino community:

- Long-term success in working with Hispanic populations requires an emphasis on relationship building, but evaluation efforts do not typically cover relational issues and are often too short-term to capture them effectively.
- Workplans and interventions have not been adequately tailored to address the specific needs of the migrant population.
- Language-competent community-based organizations (CBOs) do not often work on tobacco control, and tobacco control organizations are usually not competent to work in Hispanic/Latino communities. Better collaboration is needed.
- CBOs need resources such as increased funding and mentoring relationships to build tobacco control infrastructure capacity, especially in light of the trend toward more policy work.
- It is very difficult to find culturally competent cessation services.

## How does the tobacco industry target the Hispanic/Latino community?

The tobacco industry markets brand-specific products that are designed to be more appealing to

Hispanic/Latino consumers. For example, in recent years the tobacco industry introduced two cigarette brands called “Dorado” and “Rio;” targeted tobacco product advertising appears in bilingual and Spanish-language newspapers and magazines; and the industry has high visibility at Hispanic cultural events, festivals, and concerts.

In 2001, Philip Morris ranked 10th among the top U.S. Hispanic market advertisers with gross media expenditures totaling \$25 million. Just one year later, Philip Morris increased its spending by 156 percent to become the second largest Hispanic market advertiser. The company’s 2002 gross media expenditure in the Hispanic media market totaled \$64 million (Hispanic Business Magazine 2002).

**Cultural sensitivity can go down the drain if generational issues are not considered, even if the program is bilingual. The community will recognize the lack of sensitivity and shut you out. It’s not just about language capability.**

Rosemary Zometa, In The Zone, University and College Campus Advocacy Project (UCCAP)

In order to increase its credibility, the tobacco industry has contributed to programs that aim to enhance the primary and secondary education of Hispanic/Latino children and has supported scholarship programs for Hispanics/Latinos. The industry has also provided significant support for the Hispanic/Latino arts community (American Lung Assn. of San Diego and Imperial Counties).

According to the TIME project, in 2002-2003, California organizations receiving tobacco industry money included the following:

- California Hispanic Chamber of Commerce
- Congressional Hispanic Caucus
- Hispanic Association of Colleges and Universities
- League of United Latin American Citizens
- National Council of La Raza
- National Society of Hispanic MBAs
- Tomás Rivera Policy Institute at the University of Southern California (TIME Project 2004)



## How can local programs identify and reach out to Hispanic/Latino gatekeepers and collaborative partners?

Tobacco control advocates can look to organizations working on other issues of importance to the Hispanic/Latino community for potential partners and as models for effective community work. For example, a great deal of successful grassroots organizing has occurred surrounding the issue of affordable housing. Key components of these successful efforts include face-to-face networking and strong personal outreach.

Community representatives said that tobacco control groups must work to find issues of common interest, take the time to build lasting relationships within the community, and be willing to work on other groups' issues as well as their own.

Key informants noted that the Hispanic business community needs to become more engaged in tobacco control. There have been some successful partnerships between tobacco control coalitions and a few Hispanic Chambers of Commerce, but much more needs to be done.

The faith community also has significant potential for tobacco control partnering. A number of communities have Parish Nurse programs that do effective outreach. One example of a faith-based program is Faiths and Institutions Together for Health, located in Orange County.

Other potential resources include the following:

- Latino Coalition for a Healthy California
- California Latino Leadership United for Healthy Communities

- Hispanic Policy Forum in San Francisco
- Mexican consulates throughout California

## How can tobacco control materials and activities be made more culturally competent for the Hispanic/Latino community?

Focus group participants and key informants suggested these strategies:

- Involve the community from the earliest planning stages; ask them what they need rather than telling them what to do.
- Develop “in-person” programs; they are much more effective than phone-based or Web-based cessation programs.
- Try more “hard-hitting” anti-tobacco advertising.
- Focus on tobacco’s impact on the whole family.
- Remember that younger generations are restrained culturally from challenging or criticizing their parents and elders.
- Be aware that Hispanic/Latino people, especially children, move between two worlds and benefit from the richness of both their ancestral culture and American culture.

- Recruit teens to act as role models for younger children.

**We have  
to be flexible and  
willing to work on things that  
are not just tobacco control. We  
have to show we are willing to devote  
our time to their effort.**

Felicia Flores Workman, Dept. of Health and  
Social Services of Solano County

- Start with easy-to-grasp concepts before jumping into some of the more complex issues of tobacco control.

- Rewrite materials in Spanish and keep in mind the literacy level of the user. Translated materials are often formal and stodgy, and require a high level of literacy.

- Target Spanish-language materials to different generations within the community.
- Design materials to be eye-catching, colorful, and emotional.



- Facilitate more collaborative work between tobacco control organizations and language-capable CBOs working on other issues.
- Take advantage of community-wide events such as Cinco de Mayo celebrations, but be sure to work with the planning committees of these events from the earliest planning stages, rather than coming in later and telling them what to do.
- Emphasize the prevention of sales to minors in Hispanic/Latino neighborhoods.
- Use Spanish-language radio and television.

Examples of successful ways to integrate tobacco control into existing interests and activities of the community include smoke-free baby showers, distributing tobacco control materials at smoke-free movie nights, and having local fire departments promote smoke-free homes and cars while handing out free smoke detectors.

Strategies relevant to Hispanic/Latino youth include the following:

- Deglamorize tobacco use.
- De-emphasize the health message.
- Reveal tobacco industry tactics in local neighborhoods and communities.
- Try a social justice message; teach youth about the global nature of the tobacco problem, and how the tobacco industry exploits workers.
- Train teens and young adults to talk to younger children.

## What specific kinds of messages might resonate with the Hispanic/Latino community?

A combination of messages may be most effective; messages about health are necessary, but perceived

as stale and boring, whereas social justice issues are new and interesting.

### Health

Community representatives felt that among many segments of the Hispanic/Latino population, the hazards of tobacco use are not well known and a great deal of education is needed. In other segments of the population, there is a general awareness that smoking is unhealthy, but not a clear understanding of its impact on specific health outcomes such as heart disease. Doctors and nurses, preferably Hispanic/Latino ones, have the most credibility as messengers of health-related messages.

**We need to educate people about how to use advocacy skills and how they can make a difference. Help them understand that they can “have a voice.” People stay quiet for fear of losing autonomy or value.**

Lourdes Baezconde Garbanati,  
Keck School of Medicine of the University of  
Southern California

In terms of tobacco related illnesses, coronary heart disease is the primary cause of death and cancer is the second leading cause of death among the Hispanic/Latino population (USDHHS 1998).

### Secondhand Smoke

Given the strong emphasis on protecting children and families in Hispanic/Latino cultures, framing the prevention of secondhand smoke as a child protection issue may be very successful.

Although some subgroups of the Hispanic/Latino population need more education about the adverse effects of secondhand smoke, Hispanic/Latino households with children and adolescents are inclined to have a total ban on smoking in the home. In 2002, 79.2 percent of such households reported a ban on smoking in the home (California Tobacco Survey 2002).

### Social Justice

Members of the Hispanic/Latino population are interested to learn more about social justice issues

surrounding the exploitation of workers and governmental corruption in their countries of origin. In Mexico, for example, workers have few rights, instances of child labor are common, and tobacco workers suffer severe health effects from exposure to nicotine and pesticides. Smuggling of tobacco products is also an issue of interest in the Hispanic/Latino community.

Youth in the Hispanic/Latino community have responded favorably to counter-marketing approaches that take a “don’t tell us what to do” approach towards the tobacco industry.

sorts when they have needs or problems; they continue this custom in the United States.

**Expose  
the influence of  
the tobacco industry;  
we need to address what  
is happening in the homeland.  
Regulations that exist here are  
absent in Latin countries. People  
are used to the health messages; this  
reaches another level of consciousness  
so people don’t forget what is  
happening elsewhere. Use the  
arguments to encourage quitting  
and raise activism.**

Monse Noboa, Consultant

There is a particular need to focus on migrant workers, who are increasingly targeted by the tobacco industry, are difficult to provide services for because they move frequently, and have difficulty accessing cessation services.

Tobacco control advocates working in the Hispanic/Latino community say that it is difficult to get other community groups involved when working on policy changes.

## **What barriers and competing issues make it difficult to elevate the importance of tobacco control within the Hispanic/Latino community?**

Community representatives noted that California’s Hispanic/Latino communities face many difficult and competing issues, including the following:

- California’s high cost of living and lack of affordable housing
- Language barriers
- Unemployment and underemployment
- Lack of health insurance
- Health concerns such as obesity and diabetes

People from Mexico are sometimes reluctant to use government services for situations other than emergencies. Generally, Mexicans go to family, friends, neighbors, and local practitioners of various

## **What cessation issues exist in the Hispanic/Latino community?**

Hispanic/Latino community representatives say there are not many cessation services designed specifically for the Hispanic/Latino community, and the need is great.

Key informants said that a lot of people are uncomfortable with phone-based cessation services, finding them too impersonal. Groups are better—they fit with the tendency of Hispanics to be social and talkative. If phone-based services are the only alternative, following up with personal visits should be considered. (In 2002, 14.8 percent of the callers to the California Smokers’ Helpline were Hispanic/Latino, and 5.7 percent of the calls were conducted in Spanish.)

Generational issues also exist: the older generation may be comfortable with cessation services conducted only in Spanish, whereas the younger generation is comfortable with both Spanish and English.

## What areas are in need of further study?

Focus group participants and key informants mentioned that more research is needed to find out what works to denormalize tobacco use in populations of newly immigrated Hispanic/Latino people and migrant workers.

## Tobacco Control in the Hispanic/Latino Community: Points to Remember

### Do's

- Show respect.
- Avoid stereotyping.
- Link tobacco control to other health issues.
- Acknowledge that youth are expected to be obedient to parents and elders. Asking youth to challenge the beliefs and habits of the older generation might not be appropriate.
- Be aware of the emphasis on protecting children and the family.
- Learn about the various national and cultural groups within the larger Hispanic/Latino population.

### Hispanic culture is talkative and support groups

[can take advantage of] this characteristic. We need counselors who can relate to both Spanish and English language speakers. Generation gaps are the biggest challenge. First generation people prefer Spanish, while second generation young people prefer English.

Monse Noboa, Consultant

- Build relationships within the Hispanic/Latino community.
- Use gatekeepers and liaisons to work with the Hispanic/Latino community.
  - Get community input before starting a project.
  - Use messengers or promotoras (natural community leaders or health promoters) from within the Hispanic/Latino community to provide messages and relay information to the community about issues of importance.
- Be aware that most immigrants' worldview consists of both the "mainstream" California culture and the culture of their country of origin.
- Take into consideration key values such as familismo (loyalty to an extended family or group), personalismo (valuing people and having close relationships), simpatia (avoiding conflict and striving for harmonious relationships), and confianza (trustworthiness).

### Don'ts

- Don't buy into stereotypes:
  - Not everyone is illiterate.
  - Not everyone speaks Spanish.
  - Not everyone is from Mexico.
  - Not everyone is a migrant farm worker.

## Resources – Section 5

California Hispanic/Latino Tobacco Education Partnership, <http://www.hipartnership.org/>

The National Latino Council on Alcohol and Tobacco Prevention, <http://nlcatp.org/>

## References – Section 5

American Lung Association of San Diego and Imperial Counties/Migrant Health Education Initiative (Undated.) Available online at [http://www.lungsandiego.org/tobacco/article\\_migrant.asp](http://www.lungsandiego.org/tobacco/article_migrant.asp)

California Department of Health Services, Tobacco Control Section, California Health Interview Survey 2003.

California Department of Health Services, Tobacco Control Section. California Tobacco Survey 2002.

California Department of Health Services, Tobacco Control Section.  
California Student Tobacco Survey 2001.

Hispanic Business Magazine. December 2002. Top 60 Advertisers in the Hispanic Market, 2001 and 2002. Available at <http://www.hispanicbusiness.com/news/newsbyid.asp?id=7972&page=2>

TIME Project. 2004. Tobacco Corporate Donations in California 2002-2004. Tobacco Industry Monitoring Evaluation – TIME Project, University of Southern California. Available on the password protected Web site [http://www.tcspartners.org/Main/WebSite/PS\\$corpdonations.pdf](http://www.tcspartners.org/Main/WebSite/PS$corpdonations.pdf)

U.S. Bureau of the Census. 2002. Profile of General Demographic Characteristics for California: 2000. Available at <http://www.census.gov/prod/2002pubs/c2kprof00-ca.pdf>.

U.S. Bureau of the Census. 2001. The Hispanic Population: 2000. Available at <http://www.census.gov/prod/2001pubs/c2kbr01-3.pdf>

U.S. Department of Health and Human Services (USDHHS), Centers for Disease Control and Prevention. 2004. Prevalence of Cigarette Use Among 14 Racial/Ethnic Populations - United States, 1999-2001. Morbidity and Mortality Weekly Report (MMWR). 2004;53(3):49-52.

U.S. Department of Health and Human Services (USDHHS), Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. 1998. Tobacco Use Among U.S. Racial/Ethnic Minority Groups - African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General.

## Relevant indicators and assets for the Hispanic/Latino community

### Highly Recommended Indicators: Hispanic/Latino Community

1.1.2	<p>Number and type of tobacco advertising and promotions outside of stores</p> <p>-or-</p> <p>Proportion of businesses with a voluntary policy that regulates the extent and type of tobacco advertising and promotions outside of stores</p>
1.1.8	<p>Number and type of tobacco company sponsorship and advertising at college-related events</p> <p>-or-</p> <p>Proportion of colleges with a policy that regulates tobacco company sponsorship and advertising</p>
2.2.2	<p>Proportion of families with a smoker who report their personal vehicles are smoke-free</p> <p>-or-</p> <p>The proportion of families with a policy that does not permit smoking in their personal vehicles</p>
2.2.13	<p>Proportion of multi-unit housing owners and/or operators with a voluntary policy that restricts smoking in individual units (including balconies and patios)</p> <p>-or-</p> <p>Proportion of communities with a policy that restricts smoking in the individual units of multi-unit housing (including balconies and patios), and/or resolutions encouraging owners, managers, or developers of multi-unit housing to adopt policies creating smoke-free individual units.</p>
4.1.1	<p>Number of culturally and linguistically appropriate behavior modification-based tobacco cessation services that are available and well utilized in the community</p>

### Recommended Indicators: Hispanic/Latino Community

1.1.1	<p>Number and type of in-store tobacco advertising and promotions</p> <p>-or-</p> <p>Proportion of businesses with voluntary policies that regulate the extent and type of in-store tobacco ads and promotions</p>
1.1.2	<p>Number and type of tobacco advertising and promotions outside of stores</p> <p>-or-</p> <p>Proportion of businesses with a voluntary policy that regulates the extent and type of tobacco advertising and promotions outside of stores</p>
1.1.3	<p>Number and type of tobacco advertisements in print media such as magazines and newspapers</p> <p>-or-</p> <p>Proportion of print media organizations (e.g., magazines and newspapers) with a voluntary policy that regulates tobacco advertising</p>
1.1.9	<p>Amount of tobacco company contributions to institutions and groups such as education, research, public health, women's, cultural, entertainment, fraternity/sorority groups, and social service institutions</p> <p>-or-</p> <p>Proportion of groups and institutions such as education, research, public health, women's, cultural, entertainment, fraternity/sorority groups, and social service institutions that have a voluntary policy prohibiting tobacco company contributions</p>
2.2.1	<p>Proportion of homes with a smoker in the household who report smoking</p> <p>-or-</p> <p>Proportion of families with a policy that does not permit smoking in the home</p>

### Highly Relevant Assets: Hispanic/Latino Community

1.3	Amount of local Prop 10 funds that are appropriated for cessation and secondhand smoke education targeting pregnant women and families with young children
2.2	Amount of satisfaction among coalition or advisory committee members with program planning, involvement of the community, implementation activities, quality of services, and progress made by the project
2.5	Amount of community activism among adults to support tobacco control efforts

# Section 6: Tobacco Control Issues in the Lesbian, Gay, Bisexual, and Transgender Communities

## Key Points:

- Evidence strongly suggests that smoking prevalence rates are much higher in the Lesbian, Gay, Bisexual, and Transgender (LGBT) community than in the population as a whole.
- Mainstream tobacco control advocates must bear in mind issues of privacy, and avoid stereotypical assumptions.
- Failure to include the LGBT community in both surveillance and programming activities has hampered tobacco control efforts in the past; more research is needed.
- Much greater effort must be made to combat tobacco use among LGBT youth.
- The tobacco industry has gained the loyalty of many in the LGBT community because of its targeted advertising and sponsorship of community causes, events, and publications.
- There are many potential collaborative partners in the LGBT community; mainstream tobacco control organizations must seek out and nurture these relationships.
- Health messages and issues of social justice resonate strongly with the LGBT community.
- Expanded outreach and greater access to culturally competent cessation services are needed.

Evidence strongly suggests that smoking prevalence is greater in the Lesbian, Gay, Bisexual, and Transgender (LGBT) communities than in the general population for the following reasons:

- Cigarettes are used for emotional support.
- Cigarettes are used as a social tool that facilitates people meeting one another.
- Some in the LGBT community eroticize cigar and cigarette use.
- Many LGBT people, especially gay youth, believe that smoking is part of a gay identity.
- The LGBT community maintains a strong loyalty to marketers who reach out to the community through advertising.
- Many believe that LGBT publications need tobacco and alcohol industry ad revenue to survive.

- Few tobacco control efforts currently
- focus on the LGBT community, especially outside of California.
- LGBT persons face considerable discrimination in terms of employment, housing, credit, taxes, inheritance benefits, and the right to marry, adopt children, and serve in the military. The toll caused by this homophobia, combined with racism and sexism, contribute to higher substance abuse, especially in LGBT people of color.

The information in this chapter was collected from focus group interviews conducted in 2002, key informant interviews conducted in 2003, literature searches conducted in 2004, 2005, and 2006, and statistical reports available as of mid-2006. All of the

quotes in the chapter are excerpts from the 2003 key informant interviews. Much of the discussion that follows reflects the diverse opinions and perceptions of focus group participants and key informants, and should not be assumed to reflect in its entirety the views of CDHS/TCS.

## What are the smoking prevalence rates in the LGBT communities?

Several recent studies have shown that lesbians and gay men consistently report higher levels of cigarette smoking across all age levels than their heterosexual counterparts, with rates reportedly as high as 47 percent in some national surveys (GLMA 2001).

A California survey completed in 2004 revealed that the prevalence of smoking among adult LGBT individuals was 30.4 percent, which was more than double the statewide rate observed for the same year. Another survey showed that 27.4 percent of gay men and 32.5 percent of lesbians were current smokers (California Health Interview Survey 2003.).

To date, no empirical data on tobacco use specifically among transgender populations exist. However, smoking rates may be high among transgender persons given the prevalence of identified risk factors: poverty, low educational attainment, a high prevalence of substance use and abuse, stressful living and work environments, incarceration, HIV positive status, and sexual risk patterns (GLMA 2001).

## Who are California's LGBT communities?

There is at present no definitive answer to the question of how many LGBT people live in the United States or any of the individual states, including California. Drawing inferences from three large surveys, the General Social Survey, the National Health and Social Life Survey, and the 1990 United States Census, some researchers have concluded

that, depending upon the definitions used, between 3 percent and 7 percent of American men are gay, and between 2 percent and 7 percent of American women are lesbian (Black et al. 1999). A survey completed in 2004 estimated that there are more than one million LGBT adults living in California, with 58.5 percent of the LGBT population being female and 41.5 percent being male.

California's LGBT population likely represents a significant percentage of all LGBT people in the U.S. According to various interpretations of the 2000 U.S. Census, for example, West Hollywood and the San Francisco Bay Area were home to the nation's largest concentrations of gay and lesbian couples (Gates and Ost 2004).

### Lesbians

Lesbians are women who are sexually attracted to other women. Individual lesbians may identify openly with the LGBT community, while others disclose their sexual orientation to only a few trusted friends or relatives. There are also large numbers of lesbians who conceal their orientation to all but themselves. A considerable number of lesbians are or have been in heterosexual marriages.

Tobacco control advocates should be aware of these issues pertaining to lesbians:

- Lesbians are more likely than gay men to live in suburban and rural areas.
- One in three lesbian couples is co-parenting children.
- A high percentage of lesbian women are overweight, and health issues are a high priority.
- Women often continue to feel that they are subject to a male hierarchy in most aspects of their lives.
- Social gatherings are more likely to be potlucks rather than nights spent bar-hopping.
- Lesbians and gay men do not necessarily mix socially or see eye-to-eye on political or social issues.



## Gay men

Gay men are sexually attracted to other men. Similarly to lesbians, gay men may be “out” (openly identifying with the gay community), partly out, or not out at all.

The more highly educated gay men tend to migrate to gay urban centers, although gay men of color often live in their neighborhoods of origin.

Gay men would like tobacco advocates to know that

- Diversity within the gay community is as varied as within any other community.
- Most gays live a routine American life.
- Many gay men work “9 to 5” and “flop on the couch” when they get home.
- One in five gay male couples is co-parenting children.
- Most gay men cannot be identified by the way they dress.
- Some gays are political conservatives.
- Most gays retain values and viewpoints from their “lives of origin” (their families of origin and childhood experiences).

## Bisexuals

A bisexual person is someone who is attracted to both men and women, though not necessarily at the same time.

Many bisexuals feel they have a “preference” for one gender over another, but they do not deny their attraction for the other gender. Some bisexuals, however, have no such preference, and instead focus their attractions on qualities they see in an individual regardless of that person’s gender.

Similarly to lesbians and gay men, bisexuals may be “out” (openly identifying with the bisexual community), partly out, or not out at all.

Bisexuals have very little visibility in mainstream society, and do not always feel welcome in the gay and lesbian communities.

## Transgender People

Transgender is an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. The term may include but is not limited to transsexuals, cross-dressers, and other gender-variant people. Transgender people can be female-to-male or male-to-female. Transgender people may or may not choose to alter their bodies hormonally and/or surgically.

Although transgender people are included in the term “LGBT,” it is an uneasy alliance. The gender identification issues and experiences of transgender individuals are not the same as those of gay, lesbian, or bisexual people.

## What do the diverse populations in the LGBT communities have in common?

When working with LGBT people, community representatives say that tobacco control advocates need to be sensitive to these facts:

- People come to be affiliated with the LGBT communities through self-identification and voluntary disclosure or through being “outed” involuntarily. There is a spectrum of being “out.” At one end, individuals are self-assured and secure in their sexual orientation; at the other end, individuals may be in the very early stages of questioning their sexual orientation.
- LGBT people often live in “families of choice.” An individual gains some distance (either geographically, psychologically, or both) from his or her family of origin, makes life choices, begins to associate with like-minded friends, and creates new concentric circles of relationships that serve as an extended family.
- A person’s sexual orientation is not always his or her primary form of self-identification.
- Older LGBT people seem to have less visibility than younger LGBT people both within their LGBT communities and in the community-at-large.

- LGBT people are particularly vulnerable to tobacco use as they struggle with their sexual identity, peer group influences, family issues, and societal pressures.
- Issues of heterosexism and homophobia are ever-present; harassment, oppression, stereotyping, and victimization must be acknowledged.
- LGBT people often perceive smoking as a way to deal with the stress of living in an environment of prejudice and hostility.
- Some LGBT people face considerable pressure from their communities of origin due to religious and cultural beliefs held by some people within these communities.
- A great deal of diversity exists within each of the LGBT sub-populations, including the following:
  - Family structure (partnered or not, parenting or not)
  - Sexually active or not
  - Socioeconomic status
  - Physical health and appearance
  - Ethnic identity and/or affiliation
  - Religious identity and/or affiliation
  - Age
  - Level of political or community activism

## In what ways have mainstream tobacco control efforts failed to address the needs of the LGBT communities?

People active in the LGBT communities perceive that mainstream tobacco control efforts suffer from these shortcomings:

- A lack of tobacco-related research or services specifically for the LGBT communities
- A lack of LGBT representation in mainstream tobacco control efforts
- A lack of recognition of the LGBT

communities' broad diversity

- A lack of information about LGBT youth and their involvement in anti-tobacco efforts
- A lack of education regarding the tobacco industry's targeted marketing to these communities

## What particular issues are critical to tobacco control work with Lesbian, Gay and Bisexual youth?

According to the CDC's Youth Risk Behavior Survey (USDHHS 2003), 59 percent of teenagers who classified themselves as gay, lesbian, or bisexual reported using tobacco, compared to 35 percent of straight teens. Of this group, almost half tried their first cigarette before the age of 13. Lesbian, gay, and bisexual (LGB) teens are also four times more likely than their straight counterparts to use smokeless tobacco products.

It is generally understood that certain psychological and behavioral factors, such as low self-esteem and peer pressure, significantly influence the onset of smoking in youth. The high rate of smoking among LGB teens suggests that they experience these factors to a greater degree than their straight counterparts (Ryan et al. 2001).

In an essay called "Gay Teens and Smoking: At Least the Camel Doesn't Call Them Names or Kick Them Out of the House," author Jeff Costantino

writes that LGB teens often experience low self-esteem along with feelings of loneliness and isolation as they struggle with a profound sense of confusion over their sexual identity. The lack of positive reinforcement from society and especially their own families cause many teenagers to hide their gay inclinations in an effort to force themselves to be straight. Those teens who do finally accept themselves and tell their friends and family are frequently met

**Don't  
make  
assumptions  
about who LGBT  
are and who they  
aren't.**

Gloria Soliz, CLASH/  
The Last Drag

with anger and sadness, and many are told that the homosexual feelings will only be temporary. Most religions still preach against homosexuality, and many teens struggle to reconcile their sexuality with their spiritual beliefs. Finally, many teenagers do not know how to handle the awkward feelings that arise when friendships with members of the same sex are complicated by issues of sexual attraction.

LGB teens also report living much of their lives with an undercurrent of fear of violence and harassment. According to statistics from Parents and Friends of Lesbians and Gays (PFLAG), a support organization for families, over 90 percent of gay youth report that they sometimes or frequently hear homophobic remarks at school from other students. Many LGB teens reported hearing anti-gay remarks from school faculty and staff, and a majority said that they had experienced some form of harassment or violence. Of those that cited verbal harassment, almost half said they experienced it daily. (The PFLAG Web site has a summary of pertinent literature at <http://www.pflag.org/education/schools.html>.)

In social settings, LGB teens may use cigarettes as props to look like they belong in an adult crowd, and they may also use them as conversation starters.

LGB teens, particularly males, may also be more susceptible to the imagery associated with tobacco use and specific cigarette brands. In addition to using tobacco as a badge of adulthood, gay teens may also be using cigarettes and smokeless tobacco to “pass” as heterosexual.

## How does the tobacco industry target the LGBT communities?

The tobacco industry has a long history of targeting the LGBT communities with advertising, event sponsorships in the world of the performing

arts, and considerable financial support of AIDS organizations. Many people in the LGBT community feel a certain loyalty toward the tobacco companies that have frequently been the only source of funding keeping LGBT publications, events, and organizations in existence.

In 2002-2003, according to the TIME project, fifteen separate HIV/AIDS-related organizations in California received funding from Altria (Philip Morris), including the following:

- Mama’s Kitchen in San Diego
- Project Open Hand in San Francisco
- AIDS Project Los Angeles
- Desert AIDS Project in Palm Springs (TIME Project)

## How should local tobacco control programs identify and reach out to LGBT gatekeepers and collaborative partners?

As the Gay and Lesbian Medical Association stated in its Healthy People 2010

Companion Document, “LGBT-oriented community centers and other LGBT-affirming community-based organizations should be recognized as resources and included in developing, implementing, and evaluating culturally competent smoking cessation and prevention programs” (GLMA 2001).

**Invite people to coalition meetings and ask them to participate even if they are not experts on tobacco.**

Bob Gordon, California LGBT Tobacco Education Partnership

Key informants from the LGBT communities suggested looking to these resources:

- LGBT Community Centers in all major urban areas (22 in California)
- Gay and Lesbian Medical Association in San Francisco
- LGBT advocacy groups, such as Community Focus, and the Coalition of Lavender Americans on Smoking and Health (CLASH)

- PFLAG (Parents and Friends of Lesbians and Gays)
- The Gay Caucus of the state assembly and state senate
- Gay caucuses of professional organizations
- Organizations involved in the gay youth movement
- Gay newspapers and newsletters, travel guides, and Web sites
- Gay-Straight Alliances in local high schools
- LGBT Tobacco Education Partnership

## How can tobacco control materials and activities be made more culturally competent for the LGBT communities?

The challenge of tobacco control work in the LGBT communities lies in the fact that LGBT people who use tobacco often have many other competing issues going on in their lives, and they may view tobacco use as a fairly low priority. As one key informant said, “Know the place of tobacco issues in the community, but keep pushing it forward.”

First and foremost, tobacco control programs—their materials, activities, and staff—must be LGBT-competent, sensitive to the needs of LGBT people, and respectful of the rights of LGBT individuals to confidentiality and privacy.

Members of the LGBT communities suggested the following guidelines:

- Borrow from the HIV/AIDS model of social marketing: small groups, peer-led interventions, and innovative ideas such as home parties.
- Take advantage of gay pride celebrations.
- Don’t hold activities in religious locations.
- Help organizations and publications find alternative sources of funding to replace tobacco industry contributions.
- Try piggybacking tobacco issues with other issues of high standing. For example, try to find a link between issues the lesbian community

is concerned about, such as battered women, breast cancer, and sexism.

- Try an approach that mocks or makes a parody of mainstream culture.
- Sometimes it is best to present ideas in a “non-gay” way.
- Beware of stereotypes: the LGBT community is an extremely diverse group of men and women of every ethnic group and socioeconomic status.
- LGBT people do not realize that, as a group, they smoke more than their straight counterparts.
- A common value among LGBT people is to question authority. There may be resistance to messages that “tell people what to do.”
- Use both mainstream media and LGBT-specific media to reach the LGBT communities.

## What specific kinds of messages might resonate with the LGBT communities?

Representatives of the LGBT communities suggested three subject areas from which to draw powerful tobacco control messages: health, secondhand smoke exposure, and social justice.

### Health

As the Gay and Lesbian Medical Association’s Healthy People 2010 Companion Document points out, the burden of tobacco-related health problems is great among LGBT populations, including an increased risk of lung cancer and chronic obstructive pulmonary disease, and an increased risk for cancers, including esophageal cancer due to the co-occurrence of cigarette smoking and heavy alcohol use among LGBT individuals.

Given the high prevalence of smoking among lesbians, tobacco-related health problems may be elevated compared to women in general.

Tobacco control advocates and medical care practitioners need to remember that the lesbian community includes pregnant women (and vice

versa). Lesbian mothers-to-be may be reluctant to reveal their sexual orientation to their health care providers and may remain closeted throughout the prenatal care process.

Preliminary research suggests that transgender women smokers may face complications such as blood clots when undergoing hormone therapy. Transgender men using testosterone can be at increased risk of heart attack and stroke while smoking.

Because the main medical concern for gay men remains HIV/AIDS, linking tobacco and AIDS may be an effective message for some people.

Honesty is key—the association between adverse health outcomes from HIV/AIDS and tobacco use should not be overstated. As the

Gay and Lesbian Medical Association stated in its Healthy People 2010 Companion Document:

The medical literature contains conflicting reports on the effect of cigarette smoking on medical conditions related to the course of HIV infection. Researchers have consistently found, however, an association between cigarette smoking and bacterial pneumonia, hairy leukoplakia, oral candidiasis, and dementia related to AIDS among people with HIV. The effect of cigarette smoking on the development of Pneumocystis carinii pneumonia (PCP) and Kaposi's sarcoma (KS) is unclear. However, some research has indicated that cigarette smoking is related to the development of PCP, that smoking predicts a shorter time of progression to a diagnosis of AIDS, and that smoking is associated with a higher risk of death. Other researchers have found no relationship between smoking and incidence of PCP or KS, progression to AIDS diagnosis, or death. One study found that 57 percent of HIV-positive men and women

were current smokers. In comparison to HIV-negative individuals, HIV-positive persons were significantly more likely to smoke (GLMA 2001).

## Secondhand Smoke

Many children and adolescents living in LGBT families are exposed to secondhand smoke. LGBT parents and other LGBT adults who smoke tobacco at home need to be educated about the risks to others living in the home and encouraged to seek treatment (GLMA 2001).

**The  
LGBT community  
has always been in pursuit  
of social justice. When they learn  
that tobacco is also a social justice  
issue, they respond to the issue in a  
personal and emotional way.**

Bob Gordon, California LGBT Tobacco  
Education Partnership

## Social Justice and Anti- Tobacco Industry Messages

LGBT communities must be educated about tobacco advertising and its role in promoting tobacco use. Despite evidence that the tobacco industry aggressively targets the LGBT communities, a large number of LGBT people

appear to either disagree that tobacco companies target their community or are not aware that they are being targeted (GLMA 2001). Key informants suggested that framing anti-tobacco messages as political issues may resonate with LGBT people. They suggested messages such as:

- “Our pride is not for sale.”
- “We went through so much to ‘come out,’ we’re not going to let them kill us now.”

## What cessation issues exist for the LGBT communities?

Cessation services must be LGBT-competent, affordable, and accessible. Cessation challenges in the LGBT communities center around these issues: too few health care providers are screening for tobacco use and advising patients to quit; existing cessation services are not aware of or sensitive to

the needs and concerns of LGBT individuals; and barriers to health insurance for LGBT people restrict their ability to access cessation services and over-the-counter nicotine replacement therapies.

## Cessation issues specific to LGBT youth

Several challenges are associated with introducing tobacco cessation attempts among LGBT youth. Access to adequate health insurance that covers the cost of smoking cessation products presents the most formidable challenge. Some youth who live in metropolitan areas can participate in free or low-cost smoking cessation courses offered by LGBT community centers. Most importantly, smoking cessation efforts aimed at young LGBT people must address the psychological function that smoking serves or cessation efforts are unlikely to be effective (GLMA, citing Los Angeles County Dept. of Health Services 1999).

## Successful cessation programs in LGBT communities

Speaking to the American Legacy Foundation in 2000, Gary Humfleet, PhD, Associate Clinical Professor at the University of California, San Francisco, presented an overview of four types of treatment and prevention programs being used in the LGBT community (American Legacy Foundation 2001):

- Group-based treatment as demonstrated by “The Last Drag.” This CLASH-run smoking cessation treatment program adapts the American Lung Association model “Freedom from Smoking” for the LGBT and HIV-positive communities. The program holds a series

of two-hour sessions over six weeks in an LGBT-friendly location. The program includes smoking-related information and issues specific to the LGBT communities, such as reliance on settings with high rates of smoking for social interaction and information about the industry’s targeting of LGBT communities. The program is facilitated by an LGBT person who is knowledgeable about tobacco’s role in the LGBT communities and other important issues, such as the potential interactions of nicotine and HIV treatments.

- Individual-based treatment as demonstrated in “Out and Free:”

This self-help treatment program is based on “Stages of Change,” a model of health behavior change that has been researched and used effectively with many smokers. “Out and Free” draws parallels between the process of quitting smoking and the process of coming

out. The “Out and Free” model helps the smoker develop new skills and knowledge about quitting smoking, as well as apply skills the individual learned while coming out to the effort to quit smoking.

- Community-level cessation programs as demonstrated in the “Gay American Smokeout.” This program encourages LGBT smokers to quit smoking for at least one day. The program involves a media campaign, participation by community organizations and businesses, and direct outreach to LGBT smokers.
- Youth intervention as demonstrated by the Youth Tobacco Prevention Program in Minneapolis: This two-year project aims to reduce regular tobacco use by LGBT youth and reduce the number of adolescents who start smoking. The program’s activities include establishing a community health advisory

**Partners are important in the cessation process. Partners could attend meetings and provide support. It would be beneficial to recognize the role of the partner in a quit attempt in brochures, etc. We need to help partners understand the processes of addiction.**

Kristina Keck, National Association of Lesbian, Gay, Bisexual, and Transgender Community Centers/  
The Center Orange County

network of LGBT youth and concerned adults, training LGBT youth as community health advisors, working with youth-oriented organizations to advocate for a smoke-free environment, and promoting inclusion of LGBT youth in all tobacco prevention initiatives.

### **Points to remember about cessation:**

- People want to see others like themselves when they look around the room.
- LGBT people seeking cessation assistance often come with multiple other issues in their lives (drugs, alcohol, mental health). Cessation service providers need more training on recovery and mental health services.
- Community support for a cessation program is very important.
- What works for gay adolescents also works for gay adults.
- Many LGBT people are parents or plan to become parents. Issues related to healthy children and secondhand smoke are relevant to LGBT families.
- Recognize a continuum of change, and applaud progress. Teach people that multiple quit attempts are the norm.
- Empower people to make changes; don't tell them what to do.
- A process of consensus building and coming to an agreement is the preferred method of working through issues.
- In group cessation sessions, ground rules are important; work to create a safe space for all participants.
- The venue is extremely important; it must be accessible to all LGBT people (e.g., avoid religious facilities).
- Some people in the LGBT community can be mistrustful of the government and authority.
- Have credibility: either be from the community or build a credible relationship with the community.

### **What areas are in need of further study?**

The Legacy Foundation's 2001 Final Report for the Gay, Lesbian, Bisexual, and Transgender Forum

recommended research in the following areas:

- Surveillance research is needed to identify which LGBT sub-populations are disproportionately harmed by smoking (e.g., people of color, people of lower socioeconomic status, transgender people). These harder-hit communities should be involved in all research-related activities.
- Additional research is required to shed new light on the prevalence of tobacco use in the transgender population and to design culturally competent interventions.
- Formative research directly involving the community is needed to understand the determinants of smoking and quitting among LGBT people. Such research should use varied methodologies to uncover how identity (gender, sexual, and ethnic), socioeconomic status, geography (urban, suburban, and rural) and related issues contribute to smoking among LGBT people, how LGBT people successfully quit or cut down, and how LGBT people remain smoke-free.
- A thorough evaluation—from processes to outcomes—of culturally specific prevention and cessation services is needed. There is also a need to assess how LGBT people fare in cessation programs targeted to the general population and how those programs' best practices apply.
- Some studies have found no indication that cessation interventions differ by gender. However, they acknowledge that the issue is understudied. Women may face different stressors and barriers to quitting, such as greater likelihood of depression, weight-control concerns, and issues surrounding childcare. Thus, cessation programs should be studied for differences by gender as well as sexual orientation to ensure that these suggested differences are identified and addressed.
- Tobacco industry documents must be researched to learn how LGBT communities are targeted.
- LGBT tobacco researchers should work

with mainstream tobacco researchers when identifying “Requests for Proposals” and when reviewing grant proposals.

- Future LGBT tobacco researchers should be supported and mentored, particularly researchers from historically disenfranchised LGBT communities.

## Tobacco Control in the LGBT Communities: Points to Remember

### Do's

- Use “LGBT” (or “GLBT”), but also spell it out so people know what it means.
- Honor gay relationships and families.
- Respect domestic partnerships.
- Use inclusive language: partner rather than spouse/husband/wife.
- Be sensitive, gracious, and embracing.
- Be aware of other issues that people may be dealing with; smoking may be the “tip of the iceberg.”
- Respect the community.
- Include sexual orientation and gender identification in all levels of tobacco use surveillance.
- Include LGBT people at all levels in mainstream tobacco control efforts.
- Have the leadership of LGBT anti-tobacco efforts represent all LGBT communities, including traditionally disenfranchised segments of the LGBT community, such as transgender people, lesbian and bisexual women, people of color, LGBT youth, and people of lower socioeconomic status.
- Help LGBT communities and organizations find alternatives to tobacco industry funding.
- Educate and involve LGBT community activists and leaders in tobacco efforts.

- Include LGBT youth in all levels of tobacco control efforts.
- Be aware that religious references can be a turn-off.
- Be careful with the word “family;” to LGBT people, it often means “not for me.”
- Avoid gender-specific labels, such as waitress or actress.
- Watch out for relationship terms, such as single or married.
- Assess and build the infrastructure and capacity of LGBT communities to implement effective tobacco control efforts.
- Provide education, training, and technical assistance to mainstream tobacco efforts to address the needs of LGBT people.

### Don'ts

- Don't use the word “queer” if you are from outside the community.
- Don't use the phrase “alternative lifestyle.”
- Don't use the word “homosexual;” it has clinical connotations.
- Don't hold meetings in nonsupportive religious facilities or locations.
- Don't be afraid to engage individuals and organizations who lack experience in the tobacco field.
- Don't make assumptions, e.g., not all lesbians play softball.
- Don't make single individuals feel excluded.
- Don't say “you people.”
- Don't ask people what they do in bed.
- Don't engage in “finger wagging;” keep it fun and fresh.



## Resources – Section 6

Gay and Lesbian Medical Association (GLMA)  
<http://www.glma.org/>

Coalition of Lavender Americans on Smoking and Health, Last Drag Smoking Cessation Program  
<http://www.lastdrag.org/pages/747496/index.htm>

iQuit, a cessation resource created by UC San Francisco for LGBT  
<https://iquit.medschool.ucsf.edu/>

LGBT Tobacco Education Partnership, 415-436-9182

San Francisco Tobacco Free Project  
<http://sftfc.globalink.org/index.shtml>

## References – Section 6

American Legacy Foundation. 2001. Final Report for the Gay, Lesbian, Bisexual and Transgender Forum. Available at [http://www.americanlegacy.org/section.asp?Location=content/programs/priority/glb\\_report.asp](http://www.americanlegacy.org/section.asp?Location=content/programs/priority/glb_report.asp)

Black, D., G. Gates, S. Sanders, and L. Taylor. 1999. Center for Policy Research Working Paper No. 12, Demographics of the Gay and Lesbian Population in the United States: Evidence from Available Systematic Data Sources. Syracuse, New York: Center for Policy Research, Maxwell School of Citizenship and Public Affairs, Syracuse University.

California Department of Health Services, Tobacco Control Section.  
California Health Interview Survey 2003.

Constantino, J. "Gays Teens and Smoking: At Least the Camel Doesn't Call Them Names or Kick Them Out of the House," Gay American Smokeout, undated. Available at <http://www.gaysmokeout.net/docs/GayTeensandSmoking.pdf>

Gates, G. and J. Ost. 2004. The Gay and Lesbian Atlas. Washington, D. C.:Urban Institute Press.

Gay and Lesbian Medical Association (GLMA). 2001. Healthy People 2010, Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health, "Tobacco Use." San Francisco, California: Gay and Lesbian Medical Association.

Gay and Lesbian Medical Association (GLMA), citing the following document: Los Angeles County Department of Health Services, Tobacco Control Program. 1999. Needs Assessment Report: Bay/Lesbian/Bisexual/Transgender Tobacco Coalition.

Ryan, H., P. Wortley, A. Easton, L. Pederson, and G. Greenwood. 2001. Smoking among lesbians, gays, and bisexuals: a review of the literature. [Review] American Journal of Preventive Medicine. 21(2):142-9.

TIME Project. 2004. Tobacco Corporate Donations in California 2002-2004. Tobacco Industry Monitoring Evaluation – TIME Project, University of Southern California. Available on the password protected Web site [http://www.tcspartners.org/Main/WebSite/PS\\$corpdonations.pdf](http://www.tcspartners.org/Main/WebSite/PS$corpdonations.pdf)

U.S. Department of Health and Human Services (USDHHS/CDC), Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2003. Youth Risk Behavior Surveillance--United States.

University of California, Los Angeles (UCLA). 2002. California Health Interview Survey, 2001. Center for Health Policy Research, University of California, Los Angeles.

## Relevant indicators and assets for the LGBT community

Highly Recommended Indicators: LGBT Community	
1.1.3	<p>Number and type of tobacco advertisements in print media such as magazines and newspapers</p> <p>-or-</p> <p>Proportion of print media organizations (e.g., magazines and newspapers) with a voluntary policy that regulates tobacco advertising</p>
1.1.6	<p>Number and type of tobacco company sponsorship at public and private events including county fairs, rodeo, motor sports, other sporting events, parades, concerts, museums, dances, festivals, business, etc.</p> <p>-or-</p> <p>Proportion of entertainment and sporting venues with a voluntary policy that regulates tobacco company sponsorship including county fairs, rodeo, motor sports, other sporting events, parades, concerts, museums, dances, festivals, business, etc.</p> <p>-or-</p> <p>Proportion of communities with a policy that regulates tobacco company sponsorship at entertainment and sporting venues such as fairgrounds, concerts, museums, and events such as dance, business, festivals, etc.</p>
1.1.7	<p>Number and type of tobacco company sponsorship and advertising at bars and clubs</p> <p>-or-</p> <p>Proportion of bars and clubs with a voluntary policy prohibiting tobacco-company sponsorship and advertising</p>
1.1.9	<p>Amount of tobacco company contributions to institutions and groups such as education, research, public health, women's, cultural, entertainment, fraternity/sorority groups, and social service institutions</p> <p>-or-</p> <p>Proportion of groups and institutions such as education, research, public health, women's, cultural, entertainment, fraternity/sorority groups, and social service institutions that have a voluntary policy prohibiting tobacco company contributions</p>
4.1.1	<p>Number of culturally and linguistically appropriate behavior modification-based tobacco cessation services that are available and well utilized in the community</p>

### Recommended Indicators: LGBT Community

1.1.10	<p>Amount of tobacco industry contributions to support political campaigns of elected officials or political caucuses</p> <p>-or-</p> <p>Proportion of elected officials or political caucuses that have signed a pledge not to accept tobacco company contributions</p>
2.2.6	<p>Proportion of outdoor restaurant and bar businesses with a voluntary policy that designates outdoor dining and bar areas as smoke-free, including use of cigarettes, cigars, and hookahs</p> <p>-or-</p> <p>Proportion of communities with a policy that designates outdoor dining and bar areas as smoke-free, including use of cigarettes, cigars, and hookahs</p>
2.2.16	<p>Proportion of outdoor recreational facilities, areas, and venues with a voluntary policy that regulates smoking in places such as amusement parks, beaches, fairgrounds, parks, parades, piers, playgrounds, sport stadiums, tot lots, and zoos</p> <p>-or-</p> <p>Proportion of communities with a policy that regulates smoking at outdoor recreational facilities, areas, and venues in places such as amusement parks, beaches, fairgrounds, parks, parades, piers, playgrounds, sport stadiums, tot lots, and zoos</p>
2.2.19	<p>Proportion of businesses and venues with a voluntary policy that regulates smoking in outdoor waiting lines (e.g., movie theaters, sporting events, entertainment events, food service, restrooms, ATMs, etc.)</p> <p>-or-</p> <p>Proportion of communities with a policy that regulates smoking in outdoor waiting lines (e.g., movie theaters, sporting events, entertainment events, food service, restrooms, ATMs, etc.)</p>
3.2.4	<p>Proportion of venues with voluntary policy that prohibits the distribution of free or low-cost tobacco products, coupons, coupon offers, or rebate offers for tobacco products</p> <p>-or-</p> <p>Proportion of communities or events with a policy that prohibits the distribution of free or low-cost tobacco products, coupons, coupon offers, or rebate offers for tobacco products</p>

### Highly Relevant Assets: LGBT Community

2.2	Amount of satisfaction among coalition or advisory committee members with program planning, involvement of the community, implementation activities, quality of services, and progress made by the project
3.1	Number and diversity (i.e., ethnic, cultural, sexual orientation) of partners participating in coalition or advisory committee is relative to their proportion in the community
3.4	Extent that educational and media materials used by the agency reflect the culture, ethnicity, sexual orientation, and languages of the communities served, relative to the demographics of the community



# Section 7: Tobacco Control Issues in the Low Socioeconomic Status Community

## Key Points:

- Socioeconomic status is the single greatest predictor of smoking behavior.
- The low socioeconomic status (Low SES) community (people with annual incomes less than \$25,000 and educational attainment of no more than a high school diploma) accounts for at least 25 percent of California's population.
- The Low SES population intersects with and includes members of all of California's racial and ethnic communities, the LGBT community, and immigrants, both documented and undocumented. Women and people of color are disproportionately represented in the Low SES community.
- Cultural and social characteristics of people of Low SES are more often a function of their racial and ethnic background or their national origin, rather than a function of their belonging to the Low SES community.
- Many people in this population assume smoking is normative behavior.
- Many Low SES people receive governmental services and assistance from various community-based organizations.
- Collaborative partnerships should be developed between mainstream tobacco control organizations and agencies that serve the poor.
- Tobacco control programs should present messages in a "whole life" context, emphasizing benefits to the individual, the family, and the community.
- Challenges to cessation in the Low SES community include a prevailing pessimism about the future and the common view that tobacco use is normative behavior.

Studies from around the world have shown that tobacco use is more prevalent among people of low socioeconomic status (Low SES) than it is among people with higher levels of income and education. On a day-to-day basis, spending limited family resources on tobacco products means less money is left for food and other basic needs. Tobacco users get ill more often, incur higher medical expenses, and are less productive than their non-smoking counterparts in the workforce. Finally, death as a result of tobacco use may deprive families of income.

The information in this chapter was collected from focus group interviews conducted in 2002, key informant interviews conducted in 2003, statistical reports available as of mid-2006, and literature searches conducted in 2004, 2005, and 2006. All of the quotes in the chapter are excerpts from the 2003 key informant interviews. Much of the discussion that follows reflects the diverse opinions and perceptions of focus group participants and key informants, and should not be assumed to reflect in its entirety the views of CDHS/TCS.

## What is the smoking prevalence rate in California's Low SES community?

Socioeconomic status is the single greatest predictor of smoking behavior. The smoking prevalence rate among the Low SES population is 19.4 percent, contrasted to 6.6 percent among those with high SES. Men with low SES have a smoking prevalence of 25.7 percent, while women with low SES have a smoking prevalence of 14.0 percent (CDHS/TCS 2004, citing combined data from the California Adult Tobacco Survey and the Behavioral Risk Factor Surveillance System).

## Who is California's Low SES community?

"Low income;" "Low SES;" "below the poverty level:" these terms are used somewhat interchangeably to describe people with relatively low incomes and educational attainment, and they delineate approximately the same group of people. The varying labels and definitions make it difficult to arrive at an exact figure for the number of people in this group. Nevertheless, statistics from the 2000 United States Census provide some guidance:

- 4.5 million people (adults and children) were below the federal poverty threshold in California, representing about 14 percent of the state's population.
- Approximately 25 percent of the state's population had an income of less than \$25,000.
- The proportion of California's population age 25 and over with an educational attainment

of "less than a high school diploma" was 23.2 percent in 2000. Another 43 percent of the state's population either graduated from high school or had some college but no degree.

When Low SES status is defined by income level, individuals may move into and out of this population as their circumstances change. Sometimes, Low SES status is related more to the services provided by a social program or clinic, rather than to income level, in which case the definition assigned to Low SES can define a philosophy or grounding of that social program or clinic.

Generally speaking, Low SES populations include people who are

- Not highly educated (normally less than high school education)
- Unemployed or underemployed
- Homeless
- Working poor
- Struggling to make ends meet
  - Medically underserved (underinsured, uninsured, unable to afford basic health care)
- Incarcerated
- On Medi-Cal or in the Healthy Families Program

Women and people of color are disproportionately represented in the low SES population, but otherwise, it is difficult to generalize about such a diverse

group. Within particular communities and among particular individuals, significant differences that may influence tobacco control issues include

- Race/ethnicity/country of origin
- Language
- Gender
- Family structure
- Age

**Tobacco use is seen as normative behavior within the Low SES population. Focus groups... found that Low SES individuals believe 80-90 percent of all people smoke. Smoking is culturally accepted within the population.**

Janet Porter, National Network on Tobacco Prevention and Poverty

- Sexual orientation
- Educational attainment/literacy

Cultural and social characteristics of people of Low SES are more often a function of their racial and ethnic background or national origin, rather than a function of their belonging to the Low SES group per se. In Low SES immigrant communities, for example, many people speak little or no English and do not often access available public services. These immigrant families often live together in large extended family groups, relying on one another for childcare and care for the elderly, and pooling the incomes of several wage earners. Mothers often stay home to care for the children, and are seen in the community as “keepers of the family’s health.”

Certain populations of newer immigrants distrust people they see as government representatives, such as those in public service and some health care providers. There is also fear in some immigrant communities due to the political environment since the terrorist attacks on September 11, 2001.

New immigrants often see their Low SES situation as something that will improve over time. They believe that future generations will have a good life, and that this generation is building for the future. In contrast, many other low SES people, including many native-born Americans with family histories of being in the Low SES population for several generations, are more fatalistic and hold out little hope for a better future.

## In terms of tobacco control issues, what do the diverse groups in the Low SES community have in common?

Despite the immense diversity in the Low SES community, some commonalities exist:

- Smoking is culturally accepted within much of the population.
- Low SES people often receive health care information from friends and family, as opposed to health care providers and legitimate media sources.
- Many in the Low SES group have access to and take advantage of services provided by governmental and community based organizations (although this varies with immigration and legal status).
- This population is more transient than the state’s population as a whole; frequent moving disrupts their ability to attend meetings regularly and makes it difficult to see programs and services through to completion.
- Low SES people express great concern for the well being of their children and families.
- They are severely impacted economically by their tobacco consumption.
- Generally speaking, Low SES people are not politically active. They usually do not vote, nor do they organize and advocate at a local level around issues that impact them.

**Health clinics are gatekeepers. They provide services to those that are underinsured, so that gives great access. Medical facilities have access to a lot of families. The low SES population is accessed by health education programs through public schools and preschools.**

Jean Feeney, Council for Smoke-free Environments, Vista Community Clinic

## In what ways have mainstream tobacco control efforts failed to address the needs of the Low SES community?

According to key informants, current tobacco control programs need to improve in the areas of addressing the onslaught of tobacco advertising in low income neighborhoods, designing programs to account for the immense diversity within the Low SES population, and providing accessible and appropriate cessation services for the Low SES population.

## How does the tobacco industry target the Low SES community?

According to the Advocacy Institute report, Special Populations: Implications for State Tobacco Policy, “historically, tobacco companies have exploited the unique social and cultural circumstances of special populations through targeted marketing strategies to promote tobacco consumption within these groups” (Advocacy Institute 1998). Strategies employed by tobacco companies to market their products to Low SES consumers include the following:

- Introducing various reduced price “budget” brands, longer-length brands, and 25-pack brands (25 cigarettes for the price of 20)
- Advertising “value-oriented” brands with luxurious sounding names like True Gold and Richland
- Promoting specially priced cartons rather than individual packs
- Increasing point-of-purchase displays

- Saturating low-income neighborhood convenience stores with advertising and promotions

Tobacco companies have also sought to increase their credibility within low income populations by sponsoring cultural events in these communities, funding community improvement projects and organizations, and awarding scholarships to individuals “making a difference” in these communities.

## How should local tobacco control programs identify and reach out to Low SES gatekeepers and collaborative partners?

Building relationships with the Low SES population means bringing new players and non-traditional partners to the tobacco control table. Tobacco control agencies and coalitions must talk to community leaders and organizations that can act as liaisons to the community and must seek to collaborate with those that understand the community and have the trust of those they serve. When reaching out to potential partners, tobacco control agencies and coalitions should emphasize successes of the tobacco control movement so that people can be assured they are addressing a winnable issue.

Collaborations should be pursued with agencies that serve the poor and may not traditionally be involved in tobacco control, such as the following:

- Community based organizations and their staff that already serve the population

**This population has high television usage. People will pay their cable bill prior to worrying about whether they eat pasta or rice three days in a row. They listen to the radio in their cars. The population does not seem to access the newspaper.**

Jean Feeney, Council for Smoke-free Environments, Vista Community Clinic



- Health care providers/clinics
- Social service agencies/providers
- Substance abuse prevention programs/agencies
- Religious organizations/churches
- Maternal and child health programs
- Prenatal programs
- The Salvation Army
- Veterans groups
- Places of incarceration
- Homeless shelters
- Immigrant or ethnic-specific agencies (e.g., Arab Cultural Center)
- Migrant camps
- ESL classes (Community Colleges)
- Vocational/Trade schools
- CalWorks
- Immigration lawyers or associations of immigration lawyers
- Places where people need to go and/or where they get information to stay in the country or to maintain status
- Parents involved in their neighborhood schools

When people come to governmental agencies and community organizations, they usually need multiple services, but these services are often isolated and people get shuttled back and forth. As much as possible, tobacco control programs need to look at the whole person and find connections among clients' various needs. As one key informant said, "When basic needs are met, then they can pay attention to their health."

**To  
engage the  
Low SES population, I  
believe that you should give out  
cessation information but not push  
or nag about quitting. Programs need  
to take a broader family approach. The  
population has a lot of young children  
and is family-centered. They care  
about the health of their children.**

Jean Feeney, Council for Smoke-free  
Environments, Vista Community Clinic

## How can tobacco control materials and activities be made more culturally competent for the Low SES community?

Tobacco control advocates must work collaboratively with other health and human service agencies to address health and socioeconomic issues in a holistic approach. In this way, tobacco control programs can present messages in a "whole life" context, by emphasizing that tobacco control programs benefit the health of individuals, families, and communities.

Furthermore, tobacco control advocates must work with culturally competent organizations to devise strategies to empower people in the Low SES population to advocate for themselves. The Low SES group generally does not work on organizational policy and youth access issues, yet the tobacco industry continues to target minority populations and the Low SES community.

Tobacco control advocates working with the Low SES community suggested these additional strategies:

- Take advantage of the community's concern about youth; focus on youth access to tobacco, including the prevalence of social sources, as well as preventing youth initiation of smoking.
- Link tobacco to other substance abuse and addiction issues.
- Provide stress-reduction programs.
- Provide childcare and make accommodations for transportation difficulties.

- Use television as the medium of choice for conveying tobacco control messages.
- Create written materials that are literacy-appropriate.
- Use free promotional items and incentives.
- Make anti-tobacco messages more blunt and hard-hitting. Address smoking as an addiction.
- Train members of this community to be effective tobacco control advocates.
- Frame the issue to demonstrate the impact on children. Parents in the Low SES group do not want their children to smoke, even if they are smokers themselves.
- Because of the price sensitivity of this population, work to raise taxes on tobacco products. This has the potential to further reduce consumption and increase the number of people who quit.
- For immigrants, dispel fear and reassure individuals that participation will not affect immigration policy or their ability to stay in the U.S.

**Individuals  
in this group are  
not very trustful of the  
health care community or health  
care providers; they are often  
misinformed about health issues.**

Janet Porter, National Network on Tobacco  
Prevention and Poverty

They are also not very trustful of the health care system or health care providers. Health care information often does not “speak to them” or “reach them.” In addition, they receive a lot of health misinformation from family and friends.

One area requiring a great deal of work is the issue of smoking during pregnancy and preventing relapse after a smoke-free pregnancy.

People in this population, especially pregnant women, often lie about their smoking behavior for fear of being scolded by health care providers.

Lastly, this population is interested about possible linkages between cigarette smoking and other forms of alcohol and substance abuse, especially marijuana use.

### **Secondhand Smoke**

Key informants suggested that using secondhand smoke campaigns that target parents may be a good way to approach tobacco control in the Low SES population. This population is somewhat misinformed about secondhand smoke, places importance on the family, and has great concern for children.

In many Low SES families, the mother is the manager of the family’s health, so even if she is culturally constrained from confronting a male family member about his own smoking, she can approach him about not smoking in the home or around the children in order to protect their health.

### **Youth**

The Low SES community is concerned about youth access issues. It is known, for example, that as the price of tobacco products rises, teens get more of their tobacco from social sources. Low SES people are also concerned about what they perceive as unequal enforcement of youth access laws.

## **What specific kinds of messages might resonate with the Low SES community?**

Representatives of the low SES community suggested four subject areas from which to draw powerful tobacco control messages: health, secondhand smoke, issues pertaining to youth, and social justice.

### **Health**

Key informants said that the Low SES population is generally aware of tobacco use issues and the impact on health. They know it is harmful; however, they feel powerless to do anything about it.

## Social Justice and Anti-Tobacco Industry Messages

The following issues have the potential to be framed as social justice issues:

- The prevalence of tobacco advertising in low income neighborhoods
- Variable enforcement of youth access laws
- The lack of coverage for cessation services and products by Medicare, Medicaid, and private insurance
- Exploitation of tobacco workers in third world countries

## What barriers and competing issues make it difficult to elevate the importance of tobacco control within the Low SES community?

Tobacco use is seen as normative behavior in the Low SES community, and many people of Low SES think that a majority of all people smoke. Smoking is culturally accepted; family and friends often smoke; and people of Low SES tend to congregate in environments that are not smoke-free.

Elevating the importance of tobacco control in the Low SES population is difficult because of the many competing issues that impact this community, including

- Unemployment and underemployment
- Inadequate housing
- Lack of adequate childcare
- Poor quality schools
- Transportation challenges
- Violence
- A high level of stress
- Addiction and substance abuse issues
- Lack of health care and health insurance
- Low educational attainment and limited literacy

## What cessation issues exist in the Low SES community?

Cessation services for all populations, including Low SES ones, must be accessible, affordable, and relevant. The same issues that generally make health care inaccessible to Low SES people apply to cessation services: the working poor often lack health insurance, many Low SES people must use public transportation to get to cessation programs, and cessation medications are often prohibitively expensive (Advocacy Institute 1998).

One of the biggest barriers to successful cessation is the pessimism many Low SES people feel about the future. They often lack the motivation to take on the very difficult challenge of quitting smoking. Cessation services need to address the fact that many people in this population do not believe they can successfully quit and do not know how to go about it.

People in this population tend to lack support systems for quitting because their entire families smoke and so do their friends. Generally, they do not have smoke-free environments to support their quitting efforts. Cessation messages that stress the importance of the family and programs that help family members support each other in their efforts to quit smoking might be successful in this community.

There is also the challenge of providing culturally and linguistically appropriate services, making it important to get community input about what would work with various segments of this population.

Community representatives noted the need for cessation services tailored specifically for youth and pregnant women from low SES populations. Women of Low SES have lower rates of smoking cessation than do women of higher SES, and have a

greater need for integrated cessation programs that also teach life skills such as stress management and enhanced self-esteem (USDHHS 2001).

There is also a need to educate health care providers about the importance of encouraging individuals to quit. According to several community representatives, the majority of people in the low SES population are not being told by their health practitioners to quit.

## **Tobacco Control in the Low Socioeconomic Status Community: Points to Remember**

### **Do's**

- Be clear about what you want people to do.
- Involve the community in the planning process.
- Seek community input, then show the community how the input was used. If it wasn't used, show them why it wasn't.
- Make programs accessible.
- Address barriers.

- Use a family approach to educate tobacco users about the impact on the family.
- Use a holistic approach; look at the whole person and find connections for services they need
- Be concerned about the general welfare of the community, not just tobacco control.
- Produce specific low literacy materials that are linguistically appropriate for the population.
- Be sensitive to competing issues.
- Be proactive to reach the population (you cannot assume they will come to you).

### **Don'ts**

- Don't preach.
- Don't be negative.
- Don't be condescending.

## Resources – Section 7

National Network on Tobacco Prevention and Poverty, <http://www.nntpp.org/>

RESPECT: Resources and Education Supporting People Everywhere Controlling Tobacco — A Statewide Project of the American Lung Association of the East Bay. Tel. 916-739-8925, <http://www.breath-ala.org>

## References – Section 7

Advocacy Institute. 1998. Special Populations: Implications for State Tobacco Policy. Washington, D. C. Available at <http://www.advocacy.org/publications/mtc/specialpopulations.htm>.

California Department of Health Services, Tobacco Control Section. Behavioral Risk Factor surveillance system and California Adult Tobacco Survey; data are combined for 1994-2003. The data are weighted to the 1990 California population. For purposes of this survey, Low SES is defined as household income less than \$25,000 and highest educational status is some college. [See CDHS Press Release Number 04-30 issued 5/26/04.]

U.S. Bureau of the Census. Profile of General Demographic Characteristics for California: 2000. Available at <http://www.census.gov/prod/2002pubs/c2kprof00-ca.pdf>.

U.S. Department of Health and Human Services (USDHHS). 2001. Women and Smoking: A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Available at [http://www.cdc.gov/tobacco/sgr/sgr\\_forwomen/index.htm](http://www.cdc.gov/tobacco/sgr/sgr_forwomen/index.htm).

## Relevant indicators and assets for the Low SES community

Highly Recommended Indicators: Low SES Community	
1.3.1	Proportion of schools that provide instruction on tobacco-use prevention that meets CDC guidelines (e.g., intensive tobacco use prevention instruction in junior high/middle school years with reinforcement in high school using a curricula that provides instruction on the negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills)
2.2.1	Proportion of homes with a smoker in the household who report smoking -or- Proportion of families with a policy that does not permit smoking in the home
3.1.1	Number of compliance checks conducted by enforcement agencies for violations of policies that prohibit the sale of tobacco sales to minors and that require ID checking -or- Number of warnings, citations, and fines issued for violating policies that prohibit the sale of tobacco to minors and that require ID checking -or- Proportion of tobacco retailers in compliance with policies that prohibit the sale of tobacco to minors and that require ID checking
4.1.1	Number of culturally and linguistically appropriate behavior modification-based tobacco cessation services that are available and well utilized in the community
4.1.3	Number of tobacco cessation programs that provide free or low cost pharmacological quitting aids for cessation program participants who are not eligible for this benefit through a government or employer subsidized health insurance plan, and link the provision of free or low cost pharmacologic quitting aids to behavior modification-based tobacco cessation services

### Recommended Indicators: Low SES Community

1.2.4	Proportion of communities with policies that increase the price of tobacco products and generate revenue with a portion of the revenue earmarked for tobacco control efforts (e.g., taxes, mitigation fees)
2.2.12	Proportion of multi-unit housing complexes with a voluntary policy designating indoor common areas as smoke-free, such as laundry room, hallways, stairways, and lobby area -or- Proportion of communities with a multi-unit housing policy that prohibits smoking in indoor common areas such as laundry room, hallways, stairways, and lobby areas, and/or resolutions encouraging owners, managers, or developers of multi-unit housing to adopt policies creating smoke-free indoor common areas
3.1.6	Number of compliance checks conducted by enforcement agencies for violations of policies that prohibit the sale of single cigarettes -or- Number of warnings, citations, and fines issued for violations of policies that prohibit the sale of single cigarettes -or- Proportion of businesses in compliance with policies that prohibit the sale of single cigarettes
3.2.3	<del>The proportion of communities with policies that prohibit the sale of all tobacco products (e.g., cigarettes, smokeless tobacco and cigars) through self-service displays and which require tobacco products to be in a locked or covered case<sup>8</sup></del>
3.3.1	Proportion of minors reporting they have received tobacco products from a social source

### Highly Relevant Assets: Low SES Community

1.3	Amount of local Prop 10 funds that are appropriated for cessation and secondhand smoke education targeting pregnant women and families with young children
3.2	<del>Extent to which the LLA and other TCS-funded projects in the health jurisdiction include specific objectives in their workplans/scopes of work to address cultural or ethnic/minority communities or populations in relation to the demographics of the community<sup>9</sup></del>
3.4	Extent that educational and media materials used by the agency reflect the culture, ethnicity, sexual orientation, and languages of the communities served, relative to the demographics of the community
3.6	Extent to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to the demographics of the community

<sup>8</sup> In 2004, Indicator 3.2.3 was identified by a group of experts as a “recommended” indicator for groups working with Low SES communities to assess. In 2006, indicators were reviewed and, as a result, revised and updated. In this process, Indicator 3.2.3 was retired because state legislation has subsequently become very comprehensive in this area. Directing additional resources towards eliminating the few exemptions allowed for self-service tobacco displays in state law would not make a sufficient public health impact to warrant continued tobacco control effort in this area.

<sup>9</sup> In 2004, Asset 3.2 was selected as a “highly relevant” asset for groups working with African American communities to assess. In 2006, assets were reviewed and, as a result, updated and revised. In this process, Asset 3.2 was retired and replaced with Asset 3.6 to help ensure that a diverse group of agencies are funded to address tobacco use.





# Section 8: Resources

## Advocacy Institute

<http://www.advocacy.org>

The Advocacy Institute is a U.S. based global organization dedicated to strengthening the capacity of political, social, and economic justice advocates to influence and change public policy. The Advocacy Institute's tobacco control project provides action alerts and publications; a collection of resources that states are using to present the case for using tobacco settlement money for effective tobacco control programs; links to the leading resources in tobacco control; and numerous publications available to the public.

## Agency for Healthcare Research and Quality (AHRQ)

<http://www.ahrq.gov>

AHRQ, part of the U.S. Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. AHRQ's broad programs of research bring practical, science-based information to medical practitioners and to consumers and other health care purchasers.

## Altria Group

[http://www.altria.com/responsibility/04\\_05\\_03\\_00\\_WhoWeFund.asp](http://www.altria.com/responsibility/04_05_03_00_WhoWeFund.asp)

Altria Group, Inc., is the parent company of Kraft Foods, Philip Morris International, Philip Morris USA, and Philip Morris Capital Corporation. Altria supports nonprofit organizations working primarily in the areas of hunger, domestic violence prevention, the arts, HIV/AIDS, and the environment. Researchers can learn about the promotional activities of Philip Morris by perusing the philanthropic activities of the Altria Group.

## Altria Means Tobacco

<http://www.altriameanstobacco.com>

This site, created by a multidisciplinary research group at the University of California at San Francisco, focuses on studying the tobacco industry's promotional and political strategies.

## American Lung Association of California

<http://www.californialung.org/support/tobaccocontrol.shtml>

The American Lung Association of California and its 15 local associations work to prevent lung disease and promote lung health. Among other things, ALA of California has assumed a leading role in the fight against tobacco, helping smokers to quit, encouraging children not to start smoking, and protecting nonsmokers from secondhand smoke. For an updated listing of Master Settlement Agreement (MSA) funding by county, click on "Fact Sheets" and then "Tracking Tobacco Settlement Funds: Detailed Chart of Latest City & County Fund Allocation Plans"

## Americans for Nonsmokers' Rights

<http://www.no-smoke.org>

This site contains data on secondhand smoke, tobacco industry documents, and youth issues, as well as information on other ANR-sponsored campaigns.

## Big Tobacco Sucks

<http://www.bigtabaccosucks.org/>

The Campaign against Transnational Tobacco mobilizes students to use the investment power of their universities to challenge the global tobacco industry's violation of human rights, public health, and the environment.

## **California Children and Families Commission**

<http://www.cafc.ca.gov>

The California Children and Families Commission (funded by Proposition 10) seeks to provide all children prenatal to five years of age with a comprehensive, integrated system of early childhood development services on a community-by-community basis.

## **California Department of Education**

<http://www.cde.ca.gov/>

The public Web site for the California Department of Education (CDE) provides links to all aspects of public education in California.

## **California Department of Health Services — Tobacco Control Section**

<http://www.dhs.ca.gov/tobacco>

The public Web site for the Tobacco Control Section contains links to reports, fact sheets, evaluation resources, and other public documents.

## **California Healthy Kids**

<http://www.hkresources.org/>

California Healthy Kids is administered for the California Department of Education (CDE) and the California Department of Health Services (CDHS). It provides access to reviewed health education materials for free loan, research summaries, school health laws, program and consultant services, and links to reviewed health education Web sites.

## **California Legislative Information Web Site**

<http://www.leginfo.ca.gov>

The official site for California legislative information is maintained by the Legislative Counsel and includes information on Senate and Assembly bills, as well as a searchable database of California laws.

## **California Youth Advocacy Network**

<http://www.cyanonline.org/>

The California Youth Advocacy Network (CYAN) is dedicated to the support of youth and young adult tobacco control advocacy throughout California. By providing young people and agencies working with young people with the tangible tools for action, CYAN strives to mobilize a powerful statewide movement for tobacco control.

## **Campaign for Tobacco Free Kids (CFTK)**

<http://www.tobaccofreekids.org>

CFTK provides information about the campaign, state-specific information related to tobacco use and the tobacco settlement, downloadable reports, news highlights, and more.

## **CDC Global Tobacco**

<http://www.cdc.gov/tobacco/global/>

The Centers for Disease Control and Prevention's (CDC) Global Tobacco Control Program in the Office on Smoking and Health is dedicated to working with partners to act now to prevent future death and disease through effective and sustainable global tobacco prevention and control programs.

## **CDC HealthComm KEY Web Site**

[http://www.cdc.gov/od/oc/hcomm/hcomm\\_about.html](http://www.cdc.gov/od/oc/hcomm/hcomm_about.html)

HealthComm KEY is a database of health communication literature focusing on Communication research and practice in the context of public health. The database, developed by CDC's Office of Communication, is designed for researchers and program staff within CDC, and also for professionals, students, and others outside of CDC who are interested in health communication.

## **CDC Tobacco Information and Prevention Source (TIPS)**

<http://www.cdc.gov/tobacco>

The CDC's "TIPS" provides extensive coverage of tobacco education and prevention issues. Sections include an overview with quick tobacco information and links; publications; online full-text Surgeon General's Reports related to tobacco; Research, Data, and Reports; How To Quit Guides; educational materials; new citations; state information with national, state, and local tobacco control data, full-text publications and reports, and STATE: State Tobacco Activities Tracking & Evaluation System searchable database.

## **Center for Tobacco Cessation**

<http://www.ctcinfo.org/>

The Center for Tobacco Cessation (CTC) is an organization focused solely on tobacco cessation issues. CTC serves as a source for the best available science on cessation and works with national partners to expand the use of effective tobacco dependence treatments and activities. The organization is funded jointly by American Cancer Society and The Robert Wood Johnson Foundation.

## **CigaretteLitter.Org**

<http://www.cigarettelitter.org/>

This is an informal, non-profit organization dedicated to dramatically reducing cigarette litter across the United States. The goal is to accomplish this task by raising public awareness of the issue and educating communities about the facts regarding cigarette litter. The site advocates forming a network of smokers and non-smokers, individuals and businesses, non-profit and government organizations, local police and fire departments, and anyone else who shares the goal of a national landscape free of cigarette litter.

## **California Online Database for Enforcement (CODE)**

<http://webtecc.etr.org/code/> -

(password protected)

The California Online Database for Enforcement (CODE) is a password-protected electronic searchable Web database, which contains all tobacco control enforcement information administered by the California Department of Health Services, Tobacco Control Section (CDHS/ TCS). CODE is a state-of-the-art efficient data management system that standardizes and streamlines data collection across TCS enforcement contracts. Standardizing how information is collected enables enforcement projects and CDHS/ TCS to generate a variety of data reports.

## **Common Cause**

<http://www.commoncause.org/>

Common Cause regularly publishes investigative studies on the effects of money in politics and reports on a variety of ethics and integrity-in-government issues. The Soft Money Laundromat is a searchable database of special interest soft money contributions to the Democratic and Republican national party committees. To find reports in the Data Center, search "by Industry," then select "Tobacco." Also see <http://www.commoncause.org/states/california> for specific California information.

## **Community Level Indicators**

<http://faculty.washington.edu/~cheadle/cli/>

Community level indicators are another way of measuring community health. This Web site assists in discovering ways to monitor the health of your community; it helps those who do not have enough resources for extensive surveying and feel that existing secondary data (e.g. census data) are inadequate. It also assists those who believe that environmental factors influence health and want to find a way to measure them.

## Counting California

<http://countingcalifornia.cdlib.org/>

Counting California is an initiative committed to enhancing California citizens' access to the growing range of social science and economic data produced by government agencies. In a departure from more static formats, Counting California's single interface enables users to access public use data compiled by federal, state, and local agencies, and also allows users to collate and integrate data by topic, geography, title, and provider. Counting California also addresses the serious preservation dilemma posed by ever-changing technology and data formats, insuring easy and continuous access to historical and current information.

## C-STATS

<http://www.cstats.info/>

C-STATS provides online access to California's county, regional, and statewide tobacco resources. Developed by the California Department of Health Services, Tobacco Control Section (CDHS/TCS) and the Tobacco Education Clearinghouse of California (TECC), C-STATS provides access to a wide variety of information, including evaluation resources for local projects, publications, and local information on a broad range of tobacco-related indicators, from behavioral measures to local policies.

## Galen II Tobacco Control Archives

<http://galen.library.ucsf.edu/tobacco>

The Tobacco Control Archives (TCA) is a source for papers, unpublished documents, and electronic resources relevant to tobacco control issues in California.

## Local Program Evaluation Database

[www.tecc.org](http://www.tecc.org) (password protected)

The Local Program Evaluation Database final evaluation reports. The reports that have been rated medium or high are available in abstract format or full report format. Please contact TECC Library Staff for information on how to locate these reports.

## Monitoring the Future

<http://www.monitoringthefuture.org>

Monitoring the Future is an ongoing study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults. The Web site contains information on youth smoking trends.

## National Association of County and City Health Officials (NACCHO)

<http://www.naccho.org/GENERAL185.htm>

NACCHO is a good resource when determining programmatic resource requirements (as well as a host of other considerations). See, for example, the online version of their "Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs" document.

## National Cancer Institute's Monographs

<http://cancercontrol.cancer.gov/tcrb/monographs>

The National Cancer Institute established the Smoking and Tobacco Control Monograph series in 1991 as a means of providing a more rapid mechanism for the systematic and timely dissemination of information about emerging public health issues in smoking and tobacco use control.

## Next Generation Alliance

<http://www.tobaccofreealliance.org/>

The Next Generation California Tobacco Control Alliance is a statewide organization working to reduce the use of tobacco in California through collaboration with traditional tobacco control organizations and new partners. Designed to go beyond traditional efforts, the Alliance unites government, nonprofit, health, corporate, academic, and business organizations behind a comprehensive statewide tobacco control strategy.

## OTIS

<http://catob.esp.fsu.edu/> (password protected)

The Online Tobacco Information System (OTIS) is a password-protected searchable database which eventually will contain all tobacco control plans, progress reports, and fiscal reports administered by the California Department of Health Services, Tobacco Control Section (CDHS/TCS).

## PARTNERS Web Site

<http://www.tcspartners.org> (password protected)

This internal Web site for TCS-funded projects has a special topic area devoted to Communities of Excellence in Tobacco Control. This special topic area contains links to questionnaires, resources, Web sites, assessments tools, timelines, training/technical assistance information, and a special area in the Strategy Exchange for postings information related to Communities of Excellence.

## Prescription for Change

<http://www.rxforchange.org/about/about1.html>

This site lists tobacco free pharmacies in California by county.

## Protect Local Control

<http://www.protectlocalcontrol.org/>

Local control is at the heart of our broader goal of educating the public about the health effects caused by secondhand smoke and changing attitudes regarding smoking in ways that harm other people. A powerful change process unfolds as a community debates the issue of secondhand smoke. Letters to the editor, town hall meetings, public debate, and media coverage all ensue. During this process, the community gains an increased understanding of the health risks associated with secondhand smoke, resulting in strong community support for a law protecting nonsmokers.

## Smokefree Apartments

<http://smokefreeapartments.org/>

This is a public database of apartment houses, condominiums, and townhouse developments which are offered for rent or lease where individual buildings, including all units, are totally free of tobacco smoke. Multi-unit residential buildings which feature one third of contiguous units as smokefree can also be included.

## Smokefree Housing

<http://www.smokefreehousing.org/>

Smokefreehousing.org was created to provide a source for accessing information on smokefree housing in Northern California. This site provides a searchable database of listings.

## Smoke-Free Movies

<http://smokefreemovies.ucsf.edu/>

Site features include background information on tobacco use/promotion in the movies; a “who’s who” of people in Hollywood who contribute to and who can also help solve the problem (studios, Motion Picture Association of America, producers, directors, actors, writers, editors, property masters); steps Hollywood can take to get rid of smoking in the movies; suggested advocacy actions to take; copies of print ads in the New York Times and other publications; and links/resources.

## **Stop Teenage Addiction to Tobacco (STAT)**

<http://www.stat.org>

This site contains information for youth and parents, fact sheets, advocacy suggestions, news, information on cessation programs designed for teens, information on the tobacco industry, SYNAR, and more.

## **Technical Assistance Legal Center (TALC)**

<http://www.phi.org/talc/>

The Technical Assistance Legal Center (TALC) provides free technical assistance to California communities seeking to restrict tobacco advertising and promotions, limit tobacco sales, or divest their pension funds from tobacco stocks.

## **Thumbs Up, Thumbs Down (National)**

<http://scenemoking.org/>

A team of adults and specially selected youth volunteers completes reviews of the top 10 movies each week. The youth have a minimum of one year's experience reviewing with the Thumbs Up! Thumbs Down! Project and are selected based on their exemplary performance in the program. Reviewers use data collection sheets and provide a short analysis of their perception of tobacco depiction in the movie.

## **Thumbs Up, Thumbs Down (Local)**

<http://www.saclung.org/thumbs/report%20card%202003.pdf>

Each year teenagers in Sacramento review the top 50 domestic box office movies from the previous year for tobacco content. Movies are analyzed for perceived messages on tobacco use, who uses tobacco, and where tobacco is used. Results are then compared with data from previous years.

## **Tobacco Control Evaluation Center (TCEC)**

<http://tobaccoeval.ucdavis.edu>

The California Tobacco Control Evaluation Center provides evaluation-related resources and technical assistance to Local Lead Agencies and Competitive Grantees funded by the California Department of Health Services, Tobacco Control Section (TCS). TCEC staff members work with Local Lead Agencies, Local Program Evaluators, and Competitive Grantees to provide training, consultation, development of materials, and other tasks to help produce more effective and useful evaluations for TCS's local programs throughout the state.

## **Tobacco Education Clearinghouse of California (TECC)**

<http://www.tecc.org>

TECC offers reference and research assistance, an online circulation guide of materials to borrow, including material to help reach indicator goals (e.g., the Divestment Guide), and extensive Web links for TCS-funded projects.

## **Tobacco Education Clearinghouse of California (TECC) Project Directory**

[www.tecc.org](http://www.tecc.org) (password protected)

The online searchable California Tobacco Project Directory provides information about projects funded by the California Department of Health Services, Tobacco Control Section (CDHS/TCS). It provides project contact information, a description of each project's activities, and information about materials that projects are developing. The directory also helps facilitate communication among TCS-funded projects by allowing staff to find projects that are working with the same populations, developing materials others can use, and working on activities with which projects can collaborate. It also provides information on how projects are evaluating their objectives and who their evaluators are. The directory is searchable by project or agency name, region, project summary/objective/ intervention, keyword, materials projects are developing, subcontractors, and evaluators.

## **Tobacco Technical Assistance Consortium**

<http://www.ttac.org>

Established in 2001 through a grant from the American Cancer Society, the American Legacy Foundation, and The Robert Wood Johnson Foundation, the Tobacco Technical Assistance Consortium (TTAC) provides technical assistance, information resources, and training for state and local tobacco control programs.

## **University of Kansas' Community Building Tools**

<http://ctb.lsi.ukans.edu>

This site includes practical guidance for improving community health and development. There are more than 3,000 downloadable pages of specific, skill-building information on more than 150 community topics. Specific sections of this web site include Community Building Tools, Links to Other Web Sites, Forums and Chat Rooms, Community, Troubleshooting Guide, and Guide for Writing a Grant Proposal.

## **U.S. Census Bureau**

<http://www.census.gov/>

The Census Bureau, which is part of the U.S. Department of Commerce, serves as the leading source of data about the nation's people and economy. The sole purpose of the censuses and surveys is to collect general statistical information from individuals and establishments in order to compile statistics.

## **World Bank Group Site on Economics of Tobacco Control**

<http://www1.worldbank.org/tobacco>

The site contains information on the economics of tobacco control and provides information, analyses, reviews and links to help researchers and policymakers and to assist governments to choose and implement effective tobacco control measures.

## **World Health Organization (WHO) Tobacco Free Initiative**

<http://www.who.int/toh/>

The Tobacco Free Initiative (TFI) is a WHO cabinet project created to focus international attention, resources, and action on the global tobacco pandemic that kills four million people a year today. The site contains excerpts from speeches and press releases, as well as information about World No Tobacco Day.





